

(41)
No. 98-1949-CFX

Title: Lori Pegram, et al., Petitioners
v.
Cynthia Herdrich

Docketed:
June 7, 1999

Court: United States Court of Appeals for
the Seventh Circuit

Entry Date

Proceedings and Orders

Jun 4 1999	Petition for writ of certiorari filed. (Response due July 28, 1999)
Jun 17 1999	Order extending time to file response to petition until July 28, 1999.
Jul 28 1999	Brief of respondent Cynthia Herdrich in opposition filed.
Jul 28 1999	Motion of American Association of Health Plans, et al. for leave to file a brief as amici curiae filed.
Jul 28 1999	LODGING consisting of ten copies of articles and studies submitted by counsel for amici American Assn. of Health Plans
Jul 28 1999	Motion of Washington Legal Foundation for leave to file a brief as amicus curiae filed.
Aug 10 1999	Reply brief of petitioner Cynthia Herdrich filed.
Aug 11 1999	DISTRIBUTED. September 27, 1999
Sep 28 1999	Motion of American Association of Health Plans, et al. for leave to file a brief as amici curiae GRANTED.
Sep 28 1999	Motion of Washington Legal Foundation for leave to file a brief as amicus curiae GRANTED.
Sep 28 1999	Petition GRANTED.
	SET FOR ARGUMENT February 23, 2000.

Nov 5 1999	Order extending time to file the joint appendix and petitioners' brief on the merits to and including Friday, November 19, 1999.
Nov 18 1999	Brief amicus curiae of Ehlmann Plaintiffs filed.
Nov 19 1999	Joint appendix filed.
Nov 19 1999	Brief of petitioners Lori Pegram, et al. filed.
Nov 19 1999	Brief amicus curiae of American Medical Association filed.
Nov 19 1999	Brief amici curiae of AARP, et al. filed.
Nov 19 1999	Brief amici curiae of American Association of Health Plans, et al. filed.
Nov 19 1999	LODGING consisting of twenty bound copies of appendix material submitted by counsel for amici American Association of Health Plans, et al.
Nov 19 1999	Brief amicus curiae of Washington Legal Foundation filed.
Nov 19 1999	Brief amicus curiae of United States filed.
Dec 14 1999	Brief amici curiae of American College of Legal Medicine, et al. filed.
Dec 17 1999	CIRCULATED.
Dec 20 1999	Brief of respondent Cynthia Herdrich filed.
Dec 20 1999	Brief amicus curiae of Health Law, Policy and Ethics Scholars filed.
Dec 20 1999	Brief amici curiae of Illinois, et al. filed.
Dec 20 1999	Brief amici curiae of Health Care for All, et al. filed.
Dec 28 1999	Record filed.
Jan 4 2000	Motion of Solicitor General for leave to participate in

Entry Date

Proceedings and Orders

	oral argument as amicus curiae and for divided argument filed.
Jan 12 2000	Record filed.
Jan 18 2000	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Jan 21 2000	Reply brief of petitioners Lori Pegram, et al. filed.
Feb 23 2000	ARGUED.

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IN THE
SUPREME COURT OF THE UNITED STATES

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a health maintenance organization ("HMO") and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1404(a)(1), by implementing a managed care program in which the physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

PARTIES TO THE PROCEEDING

All parties to the proceeding are listed in the caption of the case. There are no additional parent companies or nonwholly owned subsidiaries of the parties. See Sup. Ct. R. 29.6.

TABLE OF CONTENTS

Page

QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	1
JURISDICTION	2
STATUTE INVOLVED	2
STATEMENT OF THE CASE	3
REASONS FOR GRANTING THE PETITION	9
I. THE COURT OF APPEALS' DECISION IS OF NATIONAL IMPORTANCE AND WILL HAVE AN IMMEDIATE, WIDESPREAD, AND DAMAGING IMPACT	13
II. THE DECISION OF THE COURT OF APPEALS IS WRONG AND IN SUBSTANTIAL TENSION WITH THE DECISIONS OF THIS COURT	19
A. An HMO And Its Physicians Do Not Act As Fiduciaries By Implementing Cost-Containment Incentives	19
B. An Allegation That An HMO Financially Rewards Physicians For Successful Cost- Containment Does Not State A Claim For Breach Of Fiduciary Duty	25
CONCLUSION	29

TABLE OF AUTHORITIES

CASES

	<i>Page</i>
<i>American Mfrs. Mut. Insurance Co. v. Sullivan</i> , 119 S. Ct. 977 (1999)	13
<i>DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund</i> , 520 U.S. 806 (1997)	23
<i>Donovan v. Bierwirth</i> , 680 F.2d 263 (2d Cir. 1982)	22
<i>FTC v. Indiana Federation of Dentists</i> , 476 U.S. 447 (1986)	13
<i>Hughes Aircraft Co. v. Jacobson</i> , 119 S. Ct. 755 (1999)	12,20,21,28
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	12,20,21,28
<i>Mackey v. Lanier Collection Agency & Serv., Inc.</i> , 486 U.S. 825 (1988)	23
<i>New York Conference of Blue Cross & Blue Shield Plans</i> <i>v. Travelers Insurance Co.</i> , 514 U.S. 645 (1995) ...	18,23
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	22,27
<i>Weiss v. CIGNA Healthcare, Inc.</i> , 972 F. Supp. 748 (S.D.N.Y. 1997)	29

FEDERAL STATUTES AND REGULATIONS

Act of Aug. 14, 1935, Pub. L. No. 74-271, ch. 531, § 1855, 49 Stat. 620	15
29 U.S.C. § 1002(21)(A)	2,11,19
§ 1104(a)(1)	2
§ 1108(c)(3)	28
§ 1144(a)	23
42 U.S.C. § 300e	10,14
§ 300e(c)	14,17
§ 1395w-25	10
§ 1395mm	15
§ 1396b(m)	15
42 C.F.R. § 417.479	17

SCHOLARLY AUTHORITY

D. C. McGraw, <i>Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?</i> 83 Geo. L.J. 1821 (1995)	13,14
---	-------

OTHER AUTHORITIES

American Medical Ass'n, <i>Principles of Medical Ethics</i> (1994)	10
E. Hirshfeld, <i>The Case for Physician Direction in Health Plans</i> , 3 Annals of Health Law (1994)	10
D. Temchine, <i>Seventh Circuit's ERISA Fiduciary Duty Ruling</i> , Health L. Rep. (BNA) No. 36 (Sept. 3, 1998)	16
U.S. Dep't of Health & Human Servs., <i>State Regulatory Experience With Provider-Sponsored Organizations</i> (1997)	18
U.S. General Accounting Office, GAO/HRD-94-3, <i>Managed Health Care — Effect on Employers' Costs Difficult to Measure</i> (1993)	14

IN THE SUPREME COURT OF THE UNITED STATES

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioners, Lori Pegram, M.D., Carle Clinic
Association, and Health Alliance Medical Plans, Inc.,
respectfully petition for a writ of certiorari to review the
judgment of the United States Court of Appeals for the Seventh
Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals and the dissent thereto
(App. 1a-47a) were entered on August 18, 1998, and are
reported at 154 F.3d 362 (7th Cir. 1998). The order of the
court of appeals denying the petition for rehearing and the
suggestion for rehearing *en banc* was entered on March 8,
1999; that order and the dissent from the denial of rehearing *en
banc* (App. 48a-58a) are reported at 170 F.3d 683 (7th Cir.
1998). The opinion of the United States District Court for the

Central District of Illinois, adopting a magistrate judge's recommendation that petitioners' motion to dismiss Count III of respondent's amended complaint (the count at issue here) should be granted (App. 59a-60a), is not reported. The recommendation of the magistrate judge (App. 61a-64a) is not reported. A previous opinion of the district court, granting petitioners' motion for summary judgment on two state-law counts in respondent's complaint, but also granting respondent leave to amend her complaint to state a claim under the Employee Retirement Income Security Act (App. 65a-80a), is not reported. The February 10, 1997 judgment of the district court reflecting the jury verdict in this case (App. 81a-82a) is not reported.

JURISDICTION

The court of appeals entered its judgment on August 18, 1998. Petitioners timely filed a petition for rehearing and suggestion for rehearing *en banc* on September 1, 1998. On March 8, 1999, the court of appeals issued its decision and order denying petitioners' petition for rehearing and suggestion for rehearing *en banc*. App. 48a-58a. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act of 1974, section 3(21)(A), 29 U.S.C. § 1002(21)(A), which is set forth *infra*, at 19, and section 404(a)(1), 29 U.S.C. § 1104(a)(1), which provides:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and --

(A) for the exclusive purpose of:

- (i) providing benefits to participants and their beneficiaries; and
- (ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

STATEMENT OF THE CASE

1. State Farm Insurance Company entered into a contract with petitioner, Health Alliance Medical Plans, Inc. ("HAMP") to provide medical and hospital services to State Farm's employees and their families. HAMP operates a health maintenance organization ("HMO") -- that is, a pre-paid health insurance plan which, for a fixed monthly payment per covered individual, provides health care benefits through the Carle Clinic Association ("Carle Clinic") and other participating providers. Carle Clinic is a professional medical corporation owned by its physician shareholders. In addition, Carle Clinic is the sole shareholder both of HAMP and a management entity known as the Carle Health Insurance Management Co., Inc. ("CHIMCO"). App. 4a n.3. Like other HMOs and managed care plans, the plan contains features designed to encourage cost containment, including requirements that participants and beneficiaries see Carle Clinic physicians or other participating

providers, obtain only medically-necessary treatment, and use only plan-approved facilities.¹

Respondent Cynthia Herdrich's husband was employed by State Farm; and, accordingly, she was covered under petitioners' plan. In March 1992, Herdrich's appendix ruptured as the result of allegedly improper medical treatment she received from Dr. Lori Pegram, a Carle Clinic physician. As a result, on October 21, 1992, Herdrich filed a complaint against Pegram and Carle Clinic in the Circuit Court of McLean County, Illinois, alleging professional medical negligence. On February 18, 1994, Herdrich amended her complaint to add two state-law counts (Count III, alleging a violation of the Illinois Consumer Fraud Act, and Count IV, alleging a violation of a contractual duty of good faith and fair dealing) against petitioners.

Petitioners then removed the case to federal court, asserting that the two new counts were preempted by ERISA, and further sought summary judgment on the new claims. The district court agreed that ERISA preempted both claims. The court further granted petitioners summary judgment on Count IV. It determined that, even if Count IV were re-pled as an ERISA claim, petitioners would be entitled to summary judgment, because Herdrich was seeking monetary relief,

¹ For example, the Group Subscription Certificate for CarleCare HMO, the HAMP plan under which Ms. Herdrich was covered, explains that the plan does not cover "[c]are by Physicians, other than CarleCare Physicians or Providers, or in hospitals not associated with CarleCare (except in a medical emergency or [when referred by the Primary Care Physicians])" and that X-ray and laboratory tests and services approved by the CarleCare Medical Policy Committee are covered only "when Medically Necessary, requested by the CarleCare Physician and obtained at an approved CarleCare facility." See Group Subscription Certificate (Exhibit A to Herdrich's Complaint). App. 103a, 118a.

including extra-contractual damages, which ERISA does not allow. But the court granted Herdrich "leave to submit an amended Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." App. 79a-80a.

On September 1, 1995, Herdrich filed her amended Count III. That count is the subject of the decision at issue here. In amended Count III, Herdrich alleged that petitioners breached their fiduciary duty to plan participants and beneficiaries by implementing cost-containment mechanisms that provided physicians with financial rewards based on the extent to which the plan successfully contained the costs of providing health care.²

² Specifically, Herdrich alleged that:

In breach of that [fiduciary] duty:

- a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;
- b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:
 - i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:
 - (1) minimize the use of diagnostic tests;
 - (2) minimize the use of facilities not owned by Carle; and
 - (3) minimize the use of emergency and

(continued...)

Petitioners filed a motion to dismiss amended Count III pursuant to Fed. R. Civ. P. 12(b)(6). The magistrate judge assigned, by agreement of the parties, to hear the case recommended that petitioners' motion be granted, although he also recommended that Herdrich receive one last opportunity to plead an ERISA claim. App. 64a. Herdrich objected to the magistrate judge's recommendation pursuant to Fed. R. Civ. P. 72. On April 15, 1996, however, the district court adopted the magistrate judge's recommendation of dismissal. Herdrich chose not to re-plead.

After discovery, the remaining state-law counts of Herdrich's complaint went to trial in early December 1996. The jury returned a verdict in Herdrich's favor on these state-law medical malpractice claims and awarded her \$35,000 in compensatory damages. App. 81a.

2. Herdrich then appealed the district court's earlier dismissal of the ERISA claim in amended Count III of her

² (continued)

non-emergency consultation and/or referrals to noncontracted physicians.

ii. by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency. [Complaint (quoted App. 4a n.3).]

complaint. The court of appeals reversed the judgment of dismissal.³ It determined that the bare allegation that petitioners implemented cost-containment mechanisms that included potential rewards for physicians based on the plan's financial performance sufficed to state an ERISA claim for breach of fiduciary duty. Specifically, the court of appeals held that petitioners were acting as fiduciaries when they made the judgment to establish the cost-containment measures and the financial rewards. And, the court concluded, an allegation that petitioners created and implemented a system which might create divided loyalties in a physician sufficed to state an ERISA claim for breach of fiduciary duty:

The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. [App. 18a (emphasis omitted).]

In reaching its conclusion, the court detailed its view that cost-containment mechanisms substantially erode the quality of American health care and should be eliminated. *Id.* at 24a-32a.

³ The court of appeals first determined that Herdrich had timely filed her notice of appeal. App. 9a. Petitioners do not seek review of that decision.

Finally, the court of appeals held that Herdrich had adequately pled damage to the plan as a result of the breach. *Id.* at 38a.

Judge Flaum dissented. He observed that the complaint simply "alleges that there is a conflict of interest built into the compensation structure of the health plan in question" and accepted "the Majority's conclusion that, taking the allegations of the complaint as true, 'an incentive existed for [petitioners] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses.'" App. 38a-39a. But he disagreed with the Majority's holding "that the mere existence of this asserted conflict, without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." *Id.* at 39a. As Judge Flaum explained, "many sponsors and beneficiaries of managed care plans view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently." *Id.* at 43a. Thus, "merely alleging the existence of financial incentives to limit care cannot suffice to make out a claim of breach of fiduciary duty." *Id.*

Petitioners sought rehearing and filed a suggestion for rehearing *en banc*. The court of appeals denied the petition on March 8, 1999. App. 48a-49a. Judge Easterbrook, joined by Chief Judge Posner and Judges Flaum and Wood, dissented from denial of rehearing *en banc*. The dissenting opinion persuasively explains why the issues in this case are of national importance, why the court of appeals' decision will have widespread and damaging repercussions, and why the decision is wrong. *Id.* at 49a-58a. Rather than summarize that opinion here, petitioners incorporate its points in their demonstration that this case warrants certiorari.

REASONS FOR GRANTING THE PETITION

The court of appeals held that a health maintenance organization ("HMO") and its physicians act as fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA") when they implement a managed care program in which physicians receive financial incentives to provide medical care to the HMO's members in a cost-effective manner. The court further held that the bare allegation that an HMO has adopted such cost-containment features (as numerous health plans have) states a claim for breach of fiduciary duty under ERISA. The court of appeals is wrong, and the consequences of that error are dangerous and disruptive to health care providers and the nation's overall system of health care delivery.

The court's essential holding is that ERISA health care plans "have a fiduciary duty not to adopt HMO[s] or other managed-care options," because cost-containment incentives create a conflict of interest for the health care provider. App. 54a (Easterbrook, J., dissenting from denial of rehearing *en banc*) (hereafter "Easterbrook, J., dissenting"). Accordingly, "[b]y stretching the definition of a 'fiduciary' under ERISA, [the court of appeals] has effectively foreclosed a popular option for the delivery of medical care and taken the decision out of private hands, to which ERISA committed it." *Id.* (Easterbrook, J., dissenting). This decision -- that health plans which include incentives to health care providers to contain costs are unlawful -- is of profound national importance. "Most medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option." *Id.* at 56a. (Easterbrook, J., dissenting). If the court of appeals' decision stands, then "the principal organizational forms through which medical care is delivered today are unlawful." *Id.* (Easterbrook, J., dissenting).

This consequence is contrary to the expressed will of Congress, which has expressly authorized managed health care, including HMOs. Indeed, Congress has specifically authorized HMOs to enter into contracts which financially reward their physicians for minimizing expensive treatment. See 42 U.S.C. § 300e; see also 42 U.S.C. § 1395w-25 (authorizing Medicare to contract with HMOs and other managed care organizations established by physicians). The social and economic consequences of the court of appeals' decision cannot be overstated. At a minimum, physicians and other health care providers who contract with employers to provide managed care plans now face a substantial risk that they will be sued in federal court for breach of fiduciary duty whenever a participant or beneficiary disapproves of cost-containment incentives established by the plan. Likewise, providers will face liability under ERISA whenever a participant or beneficiary questions a medical judgment that might have been affected by a cost-containment incentive. Equally to the point, the health care industry constitutes a significant sector of the United States economy, and it will be drastically affected if the current widespread use of cost-containment incentives is unlawful in ERISA plans.

It is particularly ironic that the court of appeals extended the scope of ERISA fiduciary liability in a case involving a *physician-owned* managed care plan. Physician-controlled health plans have been advocated by some as an antidote to the perceived tension between the goals of providing quality patient care and containing costs. See generally E. Hirshfeld, *The Case for Physician Direction in Health Plans*, 3 *Annals of Health Law* 81 (1994). Physician-controlled health plans hold this promise because physicians' decisions are already governed by professional ethical codes and obligations, see American Medical Ass'n, *Principles of Medical Ethics* (1994), and by the law of medical malpractice. Notwithstanding these pre-existing

ethical and legal constraints, the court of appeals found that ERISA also regulates the extent to which physicians may share in the financial consequences of their treatment decisions.

All of this damage is achieved by a vast and unwarranted expansion of the scope of fiduciary liability under ERISA. An entity is a fiduciary only "to the extent" that it has "discretionary authority or discretionary responsibility in the administration of [an ERISA] plan." 29 U.S.C. § 1002(21)(A). HMOs and other health care providers make myriad discretionary judgments when establishing and operating a health care plan, including an ERISA plan. Many such judgments -- including the cost-containment mechanism adopted -- have no direct impact on the benefits provided by an ERISA plan. Numerous HMO decisions -- e.g., a decision to require pre-approval by the plan of hospital admissions or referrals outside a defined network of providers -- might in a particular case result in a reduction in the quality of benefits under a plan or affect a provider's judgment about when and where an enrollee should receive medical services. But it simply makes no sense to characterize all such ordinary and discretionary business judgments involved in establishing and operating a plan as "fiduciary." If all such judgments are fiduciary, the federal courts must now distinguish between "good" cost-containment measures and "bad" ones, (App. 58a (Easterbrook, J., dissenting)), a task for which courts are ill-equipped and, more importantly, a task which Congress has not committed to them. Moreover, treating all such judgments as fiduciary may well have the effect of withdrawing from state regulation and state courts medical malpractice cases in which the provider's judgment is alleged to have been affected by a plan's cost-containment measures.

The court of appeals was equally wrong to conclude that Herdrich stated a claim for breach of fiduciary duty merely by alleging that an HMO gives physicians bonuses based on

successful financial performance. Herdrich asserts only that adoption of a cost-containment incentive which gives an HMO or an HMO physician divided loyalties -- to patient/beneficiaries on the one hand and to financial gain on the other -- is inherently a breach of fiduciary duty. But that is not the law under ERISA. To the contrary, ERISA expressly *permits* the same person or entity to act as a fiduciary in one context and in service of self-interest in another. For example, an employer may seek to increase its profits by reducing the costs associated with providing benefits when it acts as plan sponsor or plan designer, while simultaneously having a duty to determine eligibility for, and provide, benefits under an extant plan solely in the interest of plan participants and beneficiaries. See, e.g., *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 762-63 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890-91 (1996). Analogously here, the business judgments that help shape the design of a health care plan may be made with cost containment in mind, while benefit eligibility and delivery decisions are made with fiduciary loyalty. Far from violating ERISA, this duality is contemplated by ERISA's definition of fiduciary.

If Herdrich's allegations suffice to state a claim for fiduciary breach, then many, if not most, HMOs are unlawful, and a method of health care delivery authorized by Congress may not be utilized in ERISA welfare plans. Health plans owned by physicians or other health care providers are particularly at risk. This Court's review is warranted to correct the court of appeals' erroneous and damaging interpretation of ERISA.

I. THE COURT OF APPEALS' DECISION IS OF NATIONAL IMPORTANCE AND WILL HAVE AN IMMEDIATE, WIDESPREAD, AND DAMAGING IMPACT

A. Traditionally, health care in the United States was provided on a fee-for-service basis, and physicians and other providers of medical services were separate from the entities responsible for paying for that health care (usually, insurers). A physician provided a treatment; bills were submitted to an insurer, which paid those bills pursuant to the terms of the insurance contract. In the late 1960s and early 1970s, rapid and dramatic increases in health care costs led to the development of alternative forms of health care delivery and financing including HMOs, preferred provider organizations, and other forms of "managed care."

Generally, in a managed care plan, enrollees receive comprehensive health care coverage in exchanged for a fixed premium. The plan arranges for the enrollees' care by employing or contracting with providers. Costs are controlled through a variety of administrative mechanisms, such as utilization review, medical necessity determinations, and pre-certification of care. See, e.g., *American Mfrs. Mut. Insurance Co. v. Sullivan*, 119 S. Ct. 977, 982-83 (1999); *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 449 (1986). Often these devices are linked with financial incentives to encourage increased patient volume for participating providers and reduced reliance on non-participating providers.⁴ Such mechanisms are now routinely used to contain health care costs.

⁴ D. C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?* 83 Geo. L.J. 1821, 1821 (1995) (citing Stanley S. Wallack, *Managed Care: Practice, Pitfalls and Potential*, Health Care Financing Rev. 1991, Ann. Supp. 27).

U.S. General Accounting Office, GAO/HRD-94-3, *Managed Health Care – Effect on Employers' Costs Difficult to Measure* 4-5 (1993).⁵ Indeed, a substantial majority of HMOs use financial rewards and penalties for health care providers to promote cost-effective treatment.⁶ At issue in this case is whether employer-sponsored health plans governed by ERISA may use these commonplace mechanisms for financing and delivering health care for their participants and beneficiaries.

Congress has encouraged the development of health care delivery systems in which providers bear or share in the gains or losses of the plan. In 1972, Congress enacted the Health Maintenance Organization Act, 42 U.S.C. § 300e. The HMO Act requires HMOs to assume financial risk for the care of enrollees. Further, it specifically authorizes HMOs to place some or all of this risk on the doctors and other health care professionals providing its services:

Each [HMO] shall . . . assume full financial risk on a prospective basis for the provision of basic health services, except that a[n] [HMO] may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions. [42 U.S.C. § 300e(c).]

⁵ See also D. McGraw, *supra*, at 1823 & n.12.

⁶ See GAO Report, *supra*, at 30; D. McGraw, *supra*, at 1827 n. 39 (citing M. Rodwin, *Medicine, Money and Morals* 140 (1993)).

Likewise, Congress has encouraged the development of managed care options in the Medicare and Medicaid programs. See 42 U.S.C. § 1395mm (Medicare managed care); 42 U.S.C. § 1396b(m) (Medicaid managed care). Indeed, in the Balanced Budget Amendments of 1997, Congress specifically authorized Medicare to contract for delivery of care from risk-bearing "provider-sponsored organizations" -- entities formed by physicians or hospitals -- even if those entities do not otherwise meet the requirements of state insurance and HMO laws. See Act of Aug. 14, 1995, Pub. L. No. 74-271, ch. 531, § 1855, 49 Stat. 620 (codified as amended at 42 U.S.C. § 1395w-25). These initiatives demonstrate a congressional commitment both to development of alternative delivery systems and to the direct financial participation of physicians and other health care providers in those systems.

B. In Count III of her complaint, Herdrich alleged that petitioners breached their fiduciary duty under ERISA by establishing a cost-containment mechanism which provided physicians with a "year-end distribution" based on the savings achieved by cost containment. Thus, she alleges that financially rewarding a group of physicians for successful cost containment in the provision of health benefits is a breach of fiduciary duty under ERISA. The court of appeals held (i) that petitioners were acting as fiduciaries when they established the cost-containment mechanism, including the financial rewards for physicians; and (ii) that the allegation that petitioners had such a mechanism in place states a claim for breach of fiduciary duty. This is a decision with a significant and potentially devastating impact on an industry -- health care -- of unquestioned national importance.

If the court of appeals' decision is accepted, then "the principal organizational forms through which medical care is delivered today are unlawful." App. 56a (Easterbrook, J.,

dissenting) "Most medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option." *Id.* (Easterbrook, J., dissenting). See also *supra*, at 13-14 nn.4 & 5. The court of appeals' decision thus will reverberate throughout the health care sector of the economy. See D. Temchine, *Seventh Circuit's ERISA Fiduciary Duty Ruling*, Health L. Rep. (BNA) No. 36, at 1421 (Sept. 3, 1998) (*Herdrich* is a "frontal attack on managed care organizations' . . . cost-containment measures").

While petitioners' plan is owned by physicians, the court of appeals decision has far-reaching implications for all managed care plans. As Judge Easterbrook explained in his dissent from denial of rehearing *en banc*, the court of appeals' holding is "impossible to cabin, for the plan attacked in this case is an ordinary HMO":

If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." Unlike some other HMOs, [petitioners' HMO] is owned by its physicians, but I do not think that this makes a legal (or practical) difference. Physicians own much of the stock of HMOs organized as corporations or receive some of its profits as bonuses or salary increments; and no matter the

HMO's internal organization, the benefit to a particular physician from a particular treatment decision is minuscule. [App. 57a (emphasis supplied).]

The immediate, practical consequences of the decision are grave. Any ERISA plan employing financial rewards or penalties for cost containment is now subject to a federal suit seeking relief for an ERISA violation, including attorneys' fees. And if the court of appeals' decision is left unreviewed, such mechanisms would become unlawful and subject to judicial injunction. Extant plans would have to be scrapped and reworked. Indeed, under this decision, any cost-savings achieved by managed care would be lost. App. 56a (Easterbrook, J., dissenting). Many employers that provide health care as part of employees' benefit packages will have to rethink the terms of their employees' health benefits and compensation packages. The decision will thus alter the provision of managed care in Illinois, Indiana and Wisconsin and, more generally, will cut a costly, disruptive swath through the nation's health care industry and through the general economy.

The decision also has important consequences for Congress and the federal judiciary. In effect, the decision bypasses an express congressional authorization of managed care, including an explicit provision allowing HMOs to use methods of physician compensation that financially reward physicians for minimizing the cost of care and financially penalize physicians for failing to do so. See 42 U.S.C. § 300e(c).⁷ The court of appeals has also effectively preempted the current debate about managed care in Congress and in the

⁷ See also 42 C.F.R. § 417.479 (addressing financial incentives in the Medicare and Medicaid contexts).

States (App. 24a-29a, 31a-32a) by incorrectly ruling that many, if not most, cost-containment mechanisms are unlawful. See also generally, U.S. Dep't of Health & Human Servs., *State Regulatory Experience With Provider-Sponsored Organizations* (1997).

The decision further assigns to the federal judiciary the task of determining whether specific cost-containment mechanisms are desirable or undesirable, "commit[ting] the court[s] to a long (and I should think unhappy) course of distinguishing 'good' managed-care systems from 'bad' ones." See App. 58a (Easterbrook, J., dissenting). And, under this ruling, federal courts will assume from state courts some significant part of the burden of medical malpractice cases. This is traditionally a matter for state regulation. *E.g.*, *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 657-58 (1995). Under the court of appeals decision, however, a claim of medical malpractice based, in whole or in part, on cost-containment incentives in an employer-sponsored health plan is transformed (via ERISA) into a claim for breach of fiduciary duty. Of course, the judiciary makes many judgments in specialized areas when the Constitution or the Congress requires it to do so, but the court of appeals had to stretch ERISA out of its natural shape in order to appropriate these policy judgments for federal courts. These harmful consequences are the result of the court of appeals' incorrect interpretation of ERISA.

II. THE DECISION OF THE COURT OF APPEALS IS WRONG AND IN SUBSTANTIAL TENSION WITH DECISIONS OF THIS COURT.

A. *An HMO And Its Physicians Do Not Act As Fiduciaries By Implementing Cost-Containment Incentives.*

The court of appeals held that petitioners were acting as fiduciaries when they adopted a cost-containment mechanism that financially rewards physicians for the plan's successful cost containment. Under ERISA,

a person is a fiduciary with respect to a plan *to the extent* (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. [29 U.S.C. § 1002(21)(A) (emphasis supplied).]

A person is a fiduciary only "to the extent" that he or she is engaged in one of the defined activities. When that person is engaged in other activities that involve the exercise of discretion, he or she is not acting as a fiduciary, even though that exercise of discretion may substantially affect the plan. Thus, for example, an employer is not acting as a fiduciary when it selects a plan's terms or modifies or terminates the plan, even

though that same employer is a fiduciary when administering the plan. See, e.g., *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996).

As the court of appeals recognized, petitioners do not control the State Farm plan's assets. But, it concluded, petitioners have "discretionary authority or discretionary control respecting management of such plan" and "discretionary authority or discretionary responsibility in the administration of such plan." App. 12a (internal quotation marks omitted). The critical question, however, is not whether petitioners are *ever* ERISA fiduciaries, but whether petitioners acted as fiduciaries when they "establish[ed] one set of cost-saving incentives rather than another."⁸ *Id.* at 53a (Easterbrook, J., dissenting). As Judge Easterbrook cogently explained, an HMO's discretionary selection among different types of cost-saving mechanisms should not be deemed an exercise of discretion "'in the administration of [the] plan.'" *Id.* (alteration in original).

Initially, the adoption of cost-containment measures which are incorporated in the terms of an ERISA plan is clearly a plan design decision. Equally clearly, then -- and contrary to the court of appeals -- neither State Farm nor petitioners were acting as fiduciaries when they agreed on the terms of the plan and included in that plan cost-containment measures, such as limitations on "the doctor referral process, the nature and duration of patient treatment, and the extent to which

⁸ The court of appeals also appears to have believed that petitioners can be characterized as ERISA fiduciaries for all purposes if they are ERISA fiduciaries for any purpose. See, e.g., App. 14a ("[w]e can reasonably infer that [petitioners] were plan fiduciaries due to their discretionary authority in deciding disputed claims"). That position is flatly contradicted by this Court's holdings in *Hughes Aircraft Co.* and *Lockheed Corp.*

participants were required to use Carle-owned facilities." App. 14a (emphasis omitted). See *Hughes Aircraft Co.*, 119 S. Ct. at 763-64; *Lockheed Corp.*, 517 U.S. at 890-91.

The HMO's further decision to provide financial incentives for physicians to implement the cost-containment measures set forth in the plan also is not a fiduciary act. It does not alter or in any way directly affect the terms of a plan or a participant's entitlement to benefits under the plan. Here, for example, participants and beneficiaries covered by the State Farm plan are entitled to the health care benefits set forth in the Member Subscription Certificate (attached to Herdrich's complaint as Exhibit A (App. 89a-128a)). Herdrich does not -- and could not -- allege that petitioners enacted a cost-saving mechanism or policy that alters the terms of the plan or directly deprives a participant of benefits provided by the plan. Quite to the contrary, as the amended complaint and the plan attached thereto reflect, *the cost-saving features that Herdrich objects to are embodied in the terms of the plan itself.*

Herdrich alleged -- and the court of appeals concluded -- that petitioners' adoption of financial rewards for successful cost containment *may indirectly affect* a participant's benefits and therefore that the decision to adopt such rewards constitutes "management" or "administration" of a plan -- a fiduciary act. More specifically, Herdrich alleged that a cost-saving mechanism that financially rewards physicians may induce physicians not to provide the health care benefits set forth in the plan or to provide lower quality benefits, resulting in an indirect impact on the plan.

The words "management" and "administration" should not be interpreted so expansively as to embrace any act that may indirectly affect benefits provided under an ERISA plan. Such an interpretation would dramatically increase the scope of

fiduciary responsibility. In addition, the scope of fiduciary responsibility would become even more ill-defined, as federal courts struggle to determine how much indirect impact a business judgment must have on benefits before it can be characterized as fiduciary in nature. Cf. *Varity Corp. v. Howe*, 516 U.S. 489, 539 (1996) (explaining that an employer is not acting as a fiduciary simply "because 'an ordinary business decision turn[ed] out to have an adverse impact on the plan'").

Health care professionals and institutions that provide benefits under ERISA plans make numerous business and clinical judgments that may indirectly affect such benefits. All businesses, including health care providers, seek to control costs; virtually any cost-saving decision may indirectly affect benefits. For example, if a managed care organization were to decide to pay hospitals a set fee per in-patient admission, regardless of the patient's length of stay, that arrangement would financially reward the hospital for treating a large number of patients and discharging them as quickly as possible. Similarly, a group of physicians contracting with a health plan might decide not to invest in an expensive piece of medical equipment, even though purchasing the equipment might improve care for plan participants. Such decisions inherently involve a careful balancing of business and clinical considerations.

On the court of appeals' theory, each of these judgments and numerous others are fiduciary in nature, and federal courts must decide whether such judgments breach a fiduciary's duty to make decisions with an "eye single" to the interests of participants. See *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (Friendly, J.). That theory puts federal judges in the difficult and uncomfortable business of determining (i) how direct and substantial an effect on plan benefits is required before a business judgment is deemed fiduciary, and (ii) whether

a fiduciary judgment that a particular cost-saving mechanism should be adopted is, in the circumstances, in the overall best interest of plan beneficiaries. Properly interpreted, however, ERISA does not require federal courts to enter this thicket. Judgments that only potentially and indirectly affect benefits under an ERISA plan do not constitute management or administration of the plan and thus are not fiduciary in nature.

This Court's recent decisions in the closely related context of ERISA preemption confirm that the HMO judgments at issue here are not fiduciary in nature. ERISA preempts any state law that "relate[s] to" an ERISA benefit plan. See 29 U.S.C. § 1144(a). This Court has twice recently held that state laws which have an *indirect* economic impact on ERISA plans and which may therefore *indirectly* affect plan administration do not "relate to" an ERISA plan and thus are not preempted. See *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 659 (1995) ("[a]n indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself"); *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997) (a state law which "increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans," but nonetheless does not "relate to" an ERISA plan).⁹ If an act having an indirect economic influence on plan administration does not "relate to" an ERISA plan, *a fortiori* a judgment which may have indirect economic influence on a plan does not constitute "management" or "administration" of a plan.

⁹ Cf. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 837-41 (1988) (explaining that a law operating as an indirect source of merely economic influence on administrative decisions should not suffice to trigger preemption).

It is, of course, "possible to read 'in the administration of [the] plan' broadly in order to catch all discretionary elements of the HMO structure." App. 53a (Easterbrook, J., dissenting) (alteration in original). But this is not the most natural reading of ERISA and it threatens to derail virtually any attempt to implement cost-containment strategies:

[W]hy should courts do this? In order to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure (or that participants will select it from among options the plan offers)? The panel's opinion sounds very much like this is the objective: its lengthy condemnation of managed care, 154 F. 3d 373-79, otherwise is hard to understand. [*Id.* (Easterbrook, J., dissenting).]

Congress has authorized such cost-saving experiments, and its explicit choice should not be overruled by an overly broad reading of ERISA's definition of a fiduciary.

The court of appeals' decision also effectively deprives plan sponsors of the right to establish an ERISA welfare plan providing benefits through an HMO or other managed care option. This Court's decisions in *Hughes Aircraft Co.* and *Lockheed Corp.* hold that employers making ERISA plan-design decisions are not acting as fiduciaries and thus may select an HMO or other managed care option as a benefit provider, just as State Farm did here. But the "right" to make such a selection means little "if implementing the HMO itself violates ERISA." App. 54a (Easterbrook, J., dissenting). "What the panel has held comes to the same thing -- though by a different route -- as saying that welfare benefit plans have a fiduciary

duty not to adopt HMO or other managed-care options." *Id.* (Easterbrook, J., dissenting).

In sum, numerous business and clinical judgments made by an HMO or its physicians may, in particular instances, have some indirect effect on benefits. But such judgments do not alter a plan or deprive any participant or beneficiary of plan benefits. They therefore are *not* exercises of discretion in the "management" or "administration" of a plan resulting in fiduciary liability, but rather "exercise[s] of managerial discretion in the administration of [an HMO's] business." App. 53a (Easterbrook, J., dissenting). Because of the potentially devastating consequences of the court of appeals decision, certiorari review is warranted.

B. *An Allegation That An HMO Financially Rewards Physicians For Successful Cost-Containment Does Not State A Claim For Breach Of Fiduciary Duty.*

In amended Count III of her complaint, Herdrich alleges that the same administrators:

vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who become eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs

so as to ensure larger bonuses. [App. 18a (emphasis omitted).]

The claim is that petitioners breached their fiduciary duty because they provided annual financial rewards to their physicians for successful implementation of cost-saving measures.

The court of appeals held that this allegation by itself states a claim under ERISA. Specifically, the court of appeals concluded that -- notwithstanding a physician's ethical obligations and the specter of medical malpractice suits -- the allegation that a physician receives a financial reward at the end of the year based on the plan's overall profit margin is adequate to support an inference that a physician may deny an individual patient/beneficiary medical treatment to which he or she is entitled under an ERISA plan. Most HMOs, however, reward physicians in some way for successfully containing costs, whether through bonuses or incentives or increases in salaries. Indeed, "[p]hysicians own much of the stock of HMOs organized as corporations or receive some of its profits as bonuses or salary increments; and no matter the HMO's internal organization, the benefit to a particular physician from a particular treatment decision is minuscule." App. 57a (Easterbrook, J., dissenting).

"If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations." App. 57a (Easterbrook, J., dissenting). The cost-containment mechanism alleged -- limiting care to specified doctors and locations, limiting referrals for specialized treatment, charging per patient fees, and "reaping for the HMO's owners the benefits of reduced health-care expenditures," *id.* (Easterbrook, J., dissenting), are the principal and characteristic features of

HMOs and other managed care organizations. Indeed, the plan document (the Group Subscription Certificate) itself recites that petitioners employ cost-saving measures.¹⁰

The court of appeals, however, has ruled that plan fiduciaries may not lawfully make the judgment that adoption of cost-containment incentives for physicians is in the overall best interest of plan participants and beneficiaries. Reasonable people can and do differ about the relative efficacy and benefits of fee-for-service and managed care systems for health care delivery. But the court of appeals' decision is, as explained above, inconsistent with *Congress'* authorization of HMOs and of financial consequences for health care providers' treatment decisions. See *supra*, at 10.

In addition, the court of appeals' decision is in fundamental tension with decisions of this Court. Herdrich alleged -- and the court of appeals found -- that petitioners' provision of financial rewards to physicians for successful cost containment is unlawful simply because it creates divided loyalties in physicians when they are making health care eligibility and treatment decisions under the plan. But an allegation of divided loyalties is insufficient to state a claim for breach of fiduciary duty under ERISA. ERISA makes this clear by defining a person as a fiduciary only "to the extent that" the person is making discretionary judgments under the plan. See *Varity Corp.*, 516 U.S. at 498 (comparing ERISA's authorization of dual loyalties with *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-30 (1981) ("common law of trusts prohibits fiduciaries from holding positions that create a conflict of interest with trust beneficiaries")). Congress and this Court thus have both made clear that a person who is an ERISA fiduciary

¹⁰ See *supra*, at 4 n.1

in one setting may singlemindedly pursue his or her self-interest in another setting without breaching any fiduciary obligation under ERISA. See *Hughes Aircraft Co.*, 119 S. Ct. at 763; *Lockheed Corp.*, 517 U.S. at 890. See also ERISA § 408(c)(3), 29 U.S.C. § 1108(c)(3) (an employer may act as plan sponsor and plan administrator).

Under ERISA, for example, an employer decides what benefits to offer and makes plan design and modification decisions unencumbered by fiduciary obligations under ERISA; in so doing, the employer may keep its eye firmly fixed on the bottom line. That same employer must make coverage and eligibility decisions under the plan as a fiduciary with an "eye single" to the interests of the patient/beneficiaries. See, e.g., *Hughes Aircraft Co.*, 119 S. Ct. at 763 ("an employer's decision to amend a pension plan concerns the composition or design of the plan itself and does not implicate the employer's fiduciary duties which consist of such actions as the administration of the plan's assets"). Analogously here, an employer may decide to provide health benefits through an HMO. The HMO employs cost-containment mechanisms and makes other business judgments with an eye to increasing its profits. That same HMO, however, must make coverage and eligibility decisions under the plan with an "eye single" to the interests of the patient/beneficiaries. Cf. App. 58a (Easterbrook, J., dissenting) ("Lawyers owe fiduciary duties to their clients. Can it be that the incentive given by the partnership's reward structure to substitute the services of associates for those of partners creates a conflict of interest that invariably violates those duties? If the answer is 'no' for law firms (and that must be the right answer), it is 'no' for HMOs, in stock or partnership form").

Unlike the common law of trusts, ERISA contemplates that persons acting as ERISA fiduciaries may have such divided loyalties. Accordingly, the bare allegation that petitioners have

divided loyalties does not state a claim for breach of fiduciary duty under ERISA.¹¹ The immediate and substantial damage done to an important national industry by the court of appeals' contrary ruling amply justifies certiorari review.

CONCLUSION

The petition for certiorari should be granted.

¹¹ See, e.g., *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 753 (S.D.N.Y. 1997) ("Weiss' contention that CIGNA's compensation package [for physicians] facially violates ERISA simply because it deprives her of her right to receive 'medical opinions and referrals unsullied by mixed motives,' . . . is tantamount to a claim that risk-sharing arrangements in managed care are inherently illegal, a position that is refuted by federal and New York law. See 42 U.S.C. § 300(e)(2); 42 C.F.R. § 417.103(b); N.Y. Pub. Health Law § 4403(1)(c). Moreover, plaintiff's concern about the soundness of managed care policy is best suited for resolution by branches of government other than the judiciary.").

Respectfully submitted,

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APPENDICES

APPENDIX A

Cynthia HERDRICH, Plaintiff-Appellant,

v.

**Lori PEGRAM, M.D., Carle Clinic Association, and
Health Alliance Medical Plans, Incorporated,
Defendants-Appellees.**

No. 97-1070.

United States Court of Appeals,
Seventh Circuit.

Argued Dec. 2, 1997.
Decided Aug. 18, 1998.

Before WOOD, JR., COFFEY and FLAUM, Circuit Judges.

COFFEY, Circuit Judge.

The defendants-appellees, Carle Clinic Association, P.C. ("Carle"), Health Alliance Medical Plans, Inc. ("HAMP"), and Carle Health Insurance Management Co., Inc., operate a pre-paid health insurance plan which provides medical and hospital services. The plaintiff-appellant, Cynthia Herdrich ("Herdrich"), was covered under a plan subscription through her husband's employer, State Farm Insurance Company, an Illinois corporation. In March of 1992, Herdrich's appendix ruptured as the result of alleged improper medical treatment while she was in the care of Dr. Lori Pegram ("Pegram"), a physician who

practiced under the plan.¹ On October 21, 1992, Herdrich filed a two-count complaint, alleging medical negligence against the health plan operators. Herdrich later added counts III and IV, alleging state law fraud. The defendants, in response, contended that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempted counts III and IV, and successfully removed the case to federal court. They subsequently filed a motion for summary judgement as to counts III and IV. The trial judge granted the summary judgement motion on count IV only, and gave Herdrich leave to amend count III. In accordance with the court's instructions, Herdrich amended count III to allege that the defendants had breached their fiduciary duty to plan participants, in violation of ERISA. The defendants moved to dismiss the amended count III for failure to state a claim upon which relief could be granted. The court agreed and granted the motion. The remaining two medical negligence counts (I and II) went to trial before a jury. Herdrich prevailed on both of them. Thereafter, she filed a notice of appeal as to the trial court's dismissal of her amended count III. We reverse and remand this case to the district court (on count III) for a trial.

¹ On March 1, 1991, Dr. Pegram examined Herdrich, and acknowledged that she (Herdrich) was experiencing pain in the midline area of her groin. Six days later, March 7, Dr. Pegram discovered a six by eight centimeter inflamed mass in Herdrich's abdomen. In spite of the fact that Herdrich's appendix was noticeably inflamed on March 7, Pegram required her to wait eight more days before undergoing the necessary diagnostic procedure (ultrasound) at a Carle-staffed facility more than fifty miles away in Urbana, Illinois, rather than allowing the procedure to be performed at her local hospital in Bloomington, Illinois. It was during this eight-day waiting period that Herdrich's appendix ruptured, resulting in peritonitis.

I. BACKGROUND

This appeal arises out of a complaint filed by Herdrich in the Circuit Court of McLean County, Illinois, on October 21, 1992, against Lori Pegram, M.D. and Carle Clinic Association. Counts I and II of the plaintiff's complaint were based upon a theory of professional medical negligence. Specifically, Herdrich alleged that she suffered a ruptured appendix and, in turn, contracted peritonitis due to Pegram's negligence in failing to provide her with timely and adequate medical care. On February 18, 1994, Herdrich was granted leave to amend the complaint. In her amended complaint, she added two counts (III and IV) of state law fraud against Carle and Health Alliance Medical Plans, Inc.² The defendants removed the case to federal court, asserting that the two new counts were preempted by ERISA, and thereafter filed a motion for summary judgment as to counts III and IV only. The court granted summary judgement against Herdrich on count IV "to the extent [she] relies on § 502(a)(3)(B) [of ERISA] as a basis for monetary relief, as opposed to equitable relief," and that provision does not provide for extra-contractual damages. While the trial judge denied the defendants' summary judgment motion as to count III, he did conclude ERISA preempted that count, and granted Herdrich "leave to submit an amended

² In count III, Herdrich asserted that Carle Clinic violated the Illinois Consumer Fraud Act, 815 ILCS 505/1. *et seq.*, by failing to disclose certain material facts regarding the ownership of HAMP, as well as failing to advise her that the compensation of plan physicians was increased to the extent that they did not order diagnostic tests, utilized facilities owned by those physicians, and did not make emergency or consultation referrals. Count IV alleged that HAMP breached its duty of good faith and fair dealing by increasing its profits and the profits of its contracted physicians through minimizing the use of diagnostic tests, emergency consultation referrals, and facilities now owned by such physicians, all to the detriment of plan beneficiaries.

Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." On September 1, 1995, Herdrich filed her amended count III in accordance with the court's instructions. In it, she averred that the defendants breached their fiduciary duty to plan beneficiaries by depriving them of proper medical care and retaining the savings resulting therefrom for themselves.³ The defendants

³ Herdrich's amended count III made the following allegations, among others:

5. In March of 1991 and thereafter, plaintiff's husband was employed by State Farm Mutual Automobile Insurance Company (hereinafter "State Farm").

6. Prior to March of 1991 and annually thereafter, for valuable consideration, through State Farm, defendants sold plaintiff a subscription in CARLE CARE HMO, a pre-paid health insurance plan (hereinafter "the Plan") arranging medical and hospital services for subscribers

7. State Farm retained no right to direct or control the administration of the Plan.

8. Defendants have the exclusive right to decide all disputed and non-routine claims under the Plan.

9. Under the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan.

10. Defendant [sic] is a participant and beneficiary under the Plan and brings this action on behalf of the Plan pursuant to 29 U.S.C. § 1132(a).

11. Defendants are fiduciaries with respect to the Plan and under 29 U.S.C. § 1109(a) are obligated to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries and

a. for the exclusive purpose of:

i. providing benefits to participants and their beneficiaries; and

ii. defraying reasonable expenses of administering the Plan;

b. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.

12. In breach of that duty:

a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and

(continued...)

thereafter moved, pursuant to Rule 12 of the Federal Rules of Civil Procedure, to dismiss Herdrich's amended count III for failure to state a claim upon which relief could be granted.

By agreement, the case—including the defendants' motion to dismiss—was assigned to a magistrate judge, who recommended that the amended count III be dismissed because, in his opinion, "[t]he plaintiff fail[ed] to identify how any of the defendants is involved as a fiduciary to the Plan." He did, however, recommend that the court afford Herdrich "one last opportunity" to re-plead her claim under ERISA. Herdrich promptly filed a Rule 72 objection to the magistrate's recommendation. Less than two weeks later, on April 15, 1996,

³ (...continued)

CHIMCO;

b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

(1) minimize the use of diagnostic tests;

(2) minimize the use of facilities not owned by CARLE; and

(3) minimize the use of emergency and non-emergency consultation and/or referrals to noncontracted physicians.

ii. by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency.

13. As a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses made by HAMP and CHIMCO to CARLE, as well as those amounts which would have been realized by prudently investing those supplemental medical expenses.

the district court denied that objection and adopted the magistrate's recommendation as to count III. In so doing, it gave Herdrich 21 days from the entry of the order to re-plead her claim. Herdrich chose not to re-plead and stood on count III as amended.

The remaining counts, I and II, went to trial in early December 1996, and the jury returned a verdict in Herdrich's favor on both counts, awarding her \$35,000 in compensatory damages. She then appealed the district court's earlier dismissal of her amended count III.

II. ISSUES

On appeal, Herdrich contends that the district court erred in dismissing the amended count III of her complaint for failing to sufficiently state a claim for breach of a fiduciary duty under ERISA. The defendants contend that we lack jurisdiction to hear this case due to Herdrich's failure to file a timely notice of appeal from the order of dismissal, entered April 15, 1996. The defendants further argue that Herdrich's request for damages is inappropriate insofar as beneficiaries under an ERISA benefits plan may not recover "anything other than the benefits provided expressly in the plan."

III. DISCUSSION

A. Jurisdiction

As an initial matter, we are called upon to determine whether or not we have jurisdiction to hear this appeal. The defendants contend that Herdrich's failure to file a notice of appeal within thirty days from the district court's April 15, 1996,

order of dismissal leaves us without jurisdiction. See Fed. R.App. P. 4(a)(1) ("[I]n a civil case in which an appeal is permitted by law as of right from a district court to a court of appeals the notice of appeal . . . must be filed with the clerk of the district court within 30 days after the date of entry of the judgment or order appealed from."). Alternatively, the defendants urge that jurisdiction is improper because the April 15 order was not a "final decision" for purposes of appealability, as required by 28 U.S.C. § 1291. We disagree and think it clear that Carle and HAMP have misconstrued the law in relation to both of their arguments.

This court has jurisdiction to hear appeals from the "final decisions" of the federal district courts. 28 U.S.C. § 1291. A "final" decision is defined as one that terminates the litigation. See *Catlin v. United States*, 324 U.S. 229, 233, 65 S.Ct. 631, 633, 89 L.Ed. 911 (1945). 28 U.S.C. § 1292 also gives us jurisdiction over appeals from specified interlocutory orders.⁴

⁴ U.S.C. § 1292 provides, in relevant part:

- (a) . . . the courts of appeals shall have jurisdiction of appeals from:
 - (1) Interlocutory orders of the district courts of the United States . . . or of the judges thereof, granting, continuing, modifying, refusing or dissolving injunctions, or refusing to dissolve or modify injunctions, except where a direct review may be had in the Supreme Court;
 - (2) Interlocutory orders appointing receivers, or refusing orders to wind up receiverships or to take steps to accomplish the purposes thereof, such as directing sales or other disposals of property;
 - (3) Interlocutory decrees of such district courts or the judges thereof determining the rights and liabilities of the parties to admiralty cases in which appeals from final decrees are allowed
 - (b) When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he
- (continued...)

Generally speaking, interlocutory appeals are disfavored, and appellate courts are reluctant to exercise their discretion to grant such requests, as they all too frequently cause unnecessary delays in lower court proceedings and waste the resources of an already overburdened judicial system. See *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 473-74, 98 S.Ct. 2454, 2460-61, 57 L.Ed.2d 351 (1978). For these reasons, the preferred practice is to defer appellate review until the entry of a final judgment in order that we might rule on *all* issues at one time. See 437 U.S. at 475, 98 S.Ct. at 2461. "[E]ven if the district judge certifies the order under § 1292(b), the appellant still has the burden of persuading the court of appeals that exceptional circumstances justify a departure from the basic policy of postponing appellate review until after the entry of a final judgment." *Id.* (citation and internal quotation omitted).

A trial court's order dismissing a complaint is not a final judgment for purposes of appeal under 28 U.S.C. § 1291 because it does not terminate the litigation. See *Paganis v. Blonstein*, 3 F.3d 1067, 1070 (7th Cir.1993) ("The dismissal of a complaint does not end the litigation. . . . In contrast, a dismissal of the entire action ends the litigation and forces the plaintiff to choose between appealing the judgment or moving to reopen the judgment and amend the complaint pursuant to Fed.R.Civ.P. 59 or Rule 60. . . . Therefore, if a judgment entry dismisses only the complaint, it is not a final judgement.") (internal citations and quotations omitted). This is particularly true when one or more counts of a multiple count complaint and/or indictment are dismissed for whatever reason, and others are left intact. In such cases, an interlocutory appeal of the dismissal order is available only after the order is certified by the district court under section 1292(b), *supra*, or by entry of a

partial final judgement under Rule 54 of the Federal Rules of Civil Procedure. See *Principal Mut. Life Ins. Co. v. Cincinnati TV 64 Ltd. Partnership*, 845 F.2d 674, 676 (7th Cir.1988) (district court order granting judgment on one count but dismissing nine other counts without prejudice and expressly providing plaintiff right to reinstate seven counts was not final appealable order because it did not "terminate the litigation"). Just because the district court failed to take either of these two courses of action in the instant case does not mean we are without jurisdiction over this appeal, for the court's April 15 order of dismissal became final, and thus appealable, upon entry of final judgment on December 15, 1996.

Contrary to the jurisdictional claims made in the defendants' brief, an order which is not a final judgment when entered becomes final or appealable upon the entry of a final judgment. The appeal of this judgment renews all issues previously pleaded and resolved by the trial court in litigation. See *In the Matter of Grabill Corp.*, 983 F.2d 773, 775 (7th Cir.1993). In the case under consideration, the April 15, 1996, order dismissing Herdrich's amended count III was an interlocutory ruling, rather than a final decision, as it failed to dispose of all the issues before the court. That is, the plaintiff's counts I and II were not dismissed, and the litigation between Herdrich and the defendants was continuing. The trial court's order dismissing the plaintiff's amended count III did not become final until such time as the judgment was entered on December 5, 1996. Herdrich's appeal from the trial court's dismissal of count III of her complaint, filed on January 6, 1997, was timely in that she filed it within thirty days of the December 5 entry of judgment.

⁴ (...continued)
shall so state in writing such order.

B. *The Plaintiff Properly Stated
a Claim Under ERISA*

The defendants next contend that Herdrich has failed to state a cause of action for breach of a fiduciary duty under ERISA. As previously mentioned, the district court dismissed Herdrich's amended count III, finding that even as amended, the complaint did not state a claim upon which relief might be granted.

This court reviews dismissals of complaints *de novo*. See *Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S.Ct. 99, 102, 2 L.Ed.2d 80 (1957). "In appraising the sufficiency of the complaint we follow, of course, the accepted rule that a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Id.* A complaint must contain either direct or inferential allegations respecting all the material elements necessary to sustain a recovery under some viable legal theory. See *Sutliff, Inc. v. Donovan Cos., Inc.*, 727 F.2d 648, 654 (7th Cir.1984). But such allegations need only state a *possible* claim, not a winning claim. See, e.g., *Conley*, 355 U.S. at 45-46, 78 S.Ct. at 102; *Trevino v. Union Pac. R.R. Co.*, 916 F.2d 1230, 1234 (7th Cir.1990) ("The federal rules do not require a plaintiff to allege sufficient facts to establish his right to a judgment. All it requires [sic] . . . is a 'short and plain' . . . statement of what his claim is.") (quoting Fed.R.Civ.P. 8(a)(2)). And this court has steadfastly held that a plaintiff's complaint "need not plead facts or legal theories; it is enough to set out a claim for relief" *Nance v. Vieregge*, 147 F.3d 589, 590-91 (7th Cir.1998). Moreover, "[a] complaint may not be dismissed under Fed.R.Civ.P. 12(b)(6) just because it omits factual allegations" *La Porte County Republican Cent. Comm. v. Board of*

Comm'rs of the County of La Porte, 43 F.3d 1126, 1129 (7th Cir.1994).

ERISA is a statutory scheme which regulates all "private employee benefits plans, including both pension plans and welfare plans." *District of Columbia v. Greater Washington Bd. Of Trade*, 506 U.S. 125, 127, 113 S.Ct. 580, 582, 121 L.Ed.2d 513 (1992). The definition of a "welfare plan" includes "any plan, fund, or program" maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries "through the purchase of insurance or otherwise." *Id.* (quoting 29 U.S.C. § 1002(1)). Importantly, ERISA establishes uniform standards, including rules relating to "reporting, disclosure, and fiduciary responsibility." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137, 111 S.Ct. 478, 482, 112 L.Ed.2d 474 (1990) (citation omitted).

In order to properly state a claim for breach of fiduciary duty under ERISA, the plaintiff's complaint must allege facts which set forth: (1) that the defendants are plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted. See 29 U.S.C. § 1104(a). We are of the opinion that Herdrich's pleadings have more than sufficiently alleged each of these three elements.

1. *Fiduciary Status*

As previously explained, the district court adopted the magistrate judge's recommendation that Herdrich's amended count III be dismissed for failure to allege that the defendants were fiduciaries because "none of the defendants is even mentioned in the Subscription Agreement attached to the complaint" and "the plaintiff fails to identify how any of the

defendants is involved as a fiduciary to the Plan."⁵ We disagree with this determination.

ERISA defines the term "fiduciary" in 29 U.S.C. § 1002(21)(A), which reads, in relevant part:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority of control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Congress, when it enacted ERISA, intended that this statutory definition of "fiduciary" be broadly interpreted. As stated by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (February 25, 1974) *reprinted*, 2 Legislative History of the Employee Retirement Income Security Act of 1974 at 3293:

The Committee has adopted the view that the definition of fiduciary is of necessity broad. . . . A fiduciary need not be a person with direct access to the assets of the plan Conduct alone may in an appropriate circumstance impose fiduciary

⁵ During the pleading stage of this suit, the defendants and plaintiff took dramatically different positions from what they now argue on appeal concerning the issue of whether the defendants were plan fiduciaries. That is, Herdrich originally maintained that the defendants were not plan fiduciaries, while the defendants insisted that they were. In the parties' respective appellant briefs, however, the defendants contend that they are not fiduciaries of the Plan, whereas the plaintiff claims they are.

obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary

Consistent with the expressed intent of Congress, this court has routinely construed the ERISA term, "fiduciary," broadly. *See Chicago Bd. Options Exch., Inc. v. Connecticut Gen. Life Ins. Co.*, 713 F.2d 254, 260 (7th Cir.1983) ("It is clear that Congress intended the definition of fiduciary under ERISA to be broad"). In so doing, we have emphasized the importance of discretionary control and authority in determining who is a plan fiduciary. *See Harris Trust and Sav. Bank v. Provident Life and Accident Ins. Co.*, 57 F.3d 608, 613 (7th Cir.1995). In *Harris Trust*, for example, an employee's daughter lost her health insurance coverage when her father's company, Specialty Brands, Inc., was acquired by Campbell Soup. *See id.* at 611-12. The employee's new health plan was funded by Campbell and merely administered by Provident Life Insurance. *See id.* In concluding that Campbell was the plan fiduciary, we emphasized that it was Campbell, not Provident, who retained the right to direct and control the claims procedures and practices, as well as the right to decide all disputed and non-routine claims:

The undisputed evidence shows that the Campbell Plan was created and fully funded by Campbell. *Provident was simply hired to administer the claims process under Campbell's direction and control* in accordance with an Administrative Services Agreement. Pursuant to that agreement, *Campbell, not Provident, dictates the claims administration procedures and practices which are to be followed, and all benefits eligibility determinations must be made in accordance with*

those procedures and practices. Campbell also retains the right under the agreement to decide all disputed and non-routine claims.

Id. at 613 (emphasis added). Thus, it was the *retention of control of the claims process* that brought about Campbell's fiduciary status.

In the case *sub judice*, the magistrate, in his report and recommendation, opined that "the plaintiff fails to identify how any of the defendants is involved as a fiduciary to the plan," and that the plaintiff's amended third count "merely repeats the statutory language of § 1109(a) with regard to fiduciaries." We do not agree that Herdrich's amended count III is as "bare-bones" as the magistrate characterizes it. Although the amended third count *does* repeat some of the statutory language of ERISA, it also alleges, as in *Harris Trust*, that the "*defendants have the exclusive right to decide all disputed and non-routine claims under the plan.*" *The defendant-physicians managed the Plan, including the doctor referral process, the nature and duration of patient treatment, and the extent to which participants were required to use Carle-owned facilities. In fact, the board of directors consisted exclusively of the Plan physicians who were thus in control of each and every aspect of the HMO's governance, including their own year-end bonuses.* And, like in *Harris Trust*, Herdrich pleaded that the defendants had the exclusive right to decide all disputed and non-routine claims. In our view, this level of control satisfies ERISA's requirement that a fiduciary maintain "discretionary control and authority." We can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims.

In a last ditch effort, the defendants parrot the magistrate's observation that "none of the defendants is even

mentioned in the Subscription Agreement attached to the complaint," and contend that they are not fiduciaries of the Plan because they are not specifically named in the Plan instrument, pursuant to § 1102(a)(2) of ERISA.⁶ But the fact of the matter is that HAMP is prominently identified in the first sentence on the first page of the Plan's Group Subscription Certificate. See Group Subscription Certificate ("Carle Care HMO, a product of Health Alliance Medical Plans, Inc., is organized as a health maintenance organization to do business as a prepaid health plan in Illinois and Indiana."). Moreover, a party's fiduciary status hinges not on whether it is named in the plan agreement, but rather on whether it satisfies the statutory definition of a fiduciary in section 1002(21)(A) of ERISA, quoted *supra* p. 369-70. Contrary to the defendants' assertion, and the magistrate's conclusion, Carle and HAMP are, in fact, fiduciaries.

2. Breach of Fiduciary Duty

Having determined that the defendants are fiduciaries under ERISA, we next consider whether the direct and inferential allegations contained in Herdrich's complaint are sufficient to establish the requisite breach of a fiduciary duty. An ERISA fiduciary must perform his duties in accordance with the standards set forth in 29 U.S.C. § 1104(a)(1), which provides:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

⁶ Section 1102(a)(2) defines a "named fiduciary" as a party who is named in the plan.

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims

A fiduciary breaches its duty of care under section 1104(a)(1)(A) whenever it acts to benefit its own interests. See James F. Forden et. al., *Handbook on ERISA Litigation* § 3.03[A], at 3-53 (1994) (collecting cases). For example, ERISA expressly prohibits fiduciaries from "deal[ing] with the assets of the plan in his own interest or for his own account," or "receiv[ing] any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan." 29 U.S.C. § 1106(b). The requirement that an ERISA fiduciary act "with an eye single to the interests of the participants and beneficiaries," *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.1982), is the most fundamental of his or her duties, and "must be enforced with uncompromising rigidity." *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-30, 101 S.Ct. 2789, 2794-96, 69 L.Ed.2d 672 (1981) (citation and internal quotation omitted). This duty, the violation of which subjects a fiduciary to liability under 29 U.S.C. § 1109,⁷ is directed particularly at schemes "tainted by

⁷ Section 1109(a) of ERISA provides:

Any person who is a fiduciary with respect to a plan who breaches any of
(continued...)

a conflict of interest and thus highly susceptible to self dealing," *Lowen v. Tower Asset Management, Inc.*, 829 F.2d 1209, 1213 (2d Cir.1987), like the one at issue here.

We think a number of authorities are particularly instructive in assisting us to determine whether the allegations in Herdrich's complaint, and the logical inferences drawn therefrom, are sufficient to demonstrate that there was a breach of the defendants' fiduciary duty. In *Dasler v. E.F. Hutton & Co., Inc.*, 694 F.Supp. 624 (D.Minn.1988), for example, the defendant brokerage firm acted as fiduciary for a profit-sharing plan. In his complaint, the plaintiff-beneficiary of the plan alleged that the defendant breached its ERISA-based fiduciary duty by engaging in excessive securities trading on behalf of the plan. See *id.* at 632. The court agreed, finding "that defendants considered their own interests and commission income when making investment decisions for the plan." *Id.* Similarly, in *Amweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 991-92 (7th Cir.1993), this court held that the defendant fiduciary breached its duty of loyalty and care under ERISA when it misled its pension plan participants by failing to give them complete material information concerning the terms of reimbursement under the pension plan. And in *Shea v. Esensten*, 107 F.3d 625 (8th Cir.1997), the Eighth Circuit concluded that the defendants therein, much like Carle and HAMP, breached their fiduciary duty by *failing to disclose to plan participants a secret incentive structure that provided*

⁷ (...continued)

the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

financial rewards to primary care physicians who minimized their use of tests and referrals. See id. at 628-29.

The Northern District of Illinois, in *Ries v. Humana Health Plan, Inc.*, 1995 WL 669583 (N.D.Ill., 1995), faced facts similar to those at bar. In *Ries*, the defendant, Humana Health, obligated the participants in its health plan to fully reimburse the plan for the costs associated with his or her treatment if such costs were recovered, by way of settlement or judgment, from the party (other than the plan) who caused his or her injury or disease. *See id.* at *1. The plan generally provided coverage for 80 percent of costs, while plan participants were obligated to finance 20 percent. Although Humana routinely collected a full 80 percent reimbursement from participants, Humana was in fact not paying 80 percent of the covered medical expenses, because it covertly arranged to receive a substantial discount for its share of the charges, unbeknownst to the plan participants. *See id.* at *3. As a result, plan participants were paying more than 20 percent of the amounts received by the hospitals, and Humana was, in effect, recouping an additional bonus for itself by paying less than the 80 percent of the medical expenses, as set forth in the plan. The *Ries* court ruled that ERISA did not "*permit a plan insurer to recoup more from its insureds than it actually pays out on their behalf under the terms of undisclosed discounting arrangements with health care providers.*" *Id.* at *2 (emphasis added). The court went on to note that the "fiduciary's covert profiteering at the expense of insureds is inconsistent with its duties of acting 'solely in the interest of the participants and beneficiaries.'" *Id.* at *7 (quoting 29 U.S.C. § 1104(a)(1)(A)).

Drawing parallels to the case under consideration, Herdrich sets forth, in the amended third count of her complaint, the intricacies of the defendants' incentive structure. *The Plan dictated that the very same HMO administrators*

vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (i.e., the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

For the purposes of a motion to dismiss, we are obligated to view complaints in the light most favorable to the non-moving party and assume all factual allegations to be true. *See Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S.Ct. 1683, 1686, 40 L.Ed.2d 90 (1974). Herdrich's amended count III alleged "a claim for relief" that the incentive scheme, which invited and encouraged plan fiduciaries to place their own interests ahead of the interests of plan beneficiaries, constituted a breach of the administrators' fiduciary duty, and that "[a]s a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses" If we accept her allegations of a breach and claim of damages as true, as we are required to do, she has established sufficient grounds to defeat the motion to dismiss.

The dissent disagrees with this aspect of today's holding, which it characterizes as concluding that "the mere existence of this asserted conflict [i.e., the conflict between the incentive scheme for Carle doctors to limit medical care and treatment, on

the one hand, and the fiduciary duty of Carle to the beneficiaries, on the other], without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." That is not the conclusion we reach. Our decision does not stand for the proposition that the existence of incentives *automatically* gives rise to a breach of fiduciary duty. Rather, we hold that incentives *can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

The dissent admittedly does "not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty." In its view, such a claim might very well be viable when "there is a serious flaw in the manner in which the incentive arrangement is established. . . ." Having said this, we fail to see how it can conclude that Herdrich did not plead such a flaw in the structure of the incentive program at issue. Her amended count III included the following allegation:

- a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;
- b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

- (1) minimize the use of diagnostic tests;
- (2) *minimize the use of facilities not owned by CARLE; and*
- (3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians.

ii. by administering disputed and non-routine health insurance claims and determining:

- (1) *which claims are covered under the Plan and to what extent;*
- (2) *what the applicable standard of care is;*
- (3) *whether a course of treatment is experimental;*
- (4) *whether a course of treatment is reasonable and customary; and*
- (5) *whether a medical condition is an emergency.*

Thus, Herdrich alleges a "serious flaw" that springs from the authority of physician/owners of Carle *to simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals.* Under the terms of ERISA, Herdrich most certainly has raised

the specter that the self-dealing physician/owners in this appeal were not acting "solely in the interest of the participants" of the Plan.

The dissent also stresses that ERISA allows fiduciaries to adopt dual loyalties, and that maintaining dual loyalties does not in itself constitute a breach of fiduciary duty. We do not disagree with this contention, for it is well established that dual loyalties are tolerated under ERISA. See, e.g., *Donovan v. Bierwirth*, 538 F. Supp. 463, 468 (E.D.N.Y. 1981). Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of "loyalty" to his own financial interests. Tolerance, in other words, has its limits.

In *Donovan*, the defendant, an executive of the Grumman Corporation, served as a trustee of the corporation's pension fund, and invested the fund's finances in Grumman stock. See *id.* at 465. The court ruled that although the defendant had dual loyalties when he acted as an officer of the fund-sponsoring corporation, his primary loyalty to the fund was the only loyalty that could affect his judgment. See *id.* at 468. The court found that ERISA authorizes "a trustee to invest in sponsor corporation stock in spite of dual loyalties and conflicting interests so long as (1) he acts exclusively for the benefit of the plan beneficiaries and participants and otherwise complies with ERISA section [1104], and (2) his actions are not violative of the proscriptions of ERISA section [1106]."⁸ *Id.* at 469. A trustee with such dual loyalties has an obligation to act

⁸ Section 1104(a)(1) of ERISA provides that a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."

fairly and equitably on behalf of those concerned with the result of the action taken. See *Donovan*, 538 F. Supp. at 469 (citation omitted).

The dissent, presumably, would not agree with *Donovan's* effort to mark the border between an acceptable dual loyalty and the impermissible breach of fiduciary duty. From our reading, the dissent would not mark a border at all. It seems to argue that dual loyalties, and incentive schemes generally, are *per se* valid almost without limitation, and that only when there is a "breakdown in the market," or some "serious flaw" in the manner in which the incentive arrangement in question is established, can there possibly be a breach of fiduciary duty. Specifically, the dissent notes, without citation to any authority, that "plan sponsors are likely to take their business elsewhere if they perceive that incentives are working to the detriment of beneficiaries or the plan itself, and thus market forces go a long way towards ensuring that incentives do not rise to dangerous or undesirable levels."

To our way of thinking, the dissent's market theory flies in the face of the facts as set forth in the very record before us. On March 7, 1991, Pegram, Herdrich's doctor, discovered a six by eight centimeter "mass" (later determined to be her appendix) in Herdrich's abdomen. Although the mass was inflamed on March 7, Pegram delayed instituting an immediate treatment of Herdrich, and forced her to wait more than one week (eight days) to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass. Ideally, Herdrich should have had the ultrasound administered with all speed after the inflamed mass was discovered in her abdomen in order that her condition

could be diagnosed and treated before deteriorating as it did,⁹ but Carle's policy requires plan participants to receive medical care from Carle-staffed facilities in what they classify as "non-emergency" situations. Because Herdrich's treatment was considered to be "non-emergency," she was forced to wait the eight days before undergoing the ultrasound at a Carle facility in Urbana, Illinois. During this unnecessary waiting period, Herdrich's health problems were exacerbated and the situation rapidly turned into an "emergency"—her appendix ruptured, resulting in the onset of peritonitis. In an effort to defray the increased costs associated with the surgery required to drain and cleanse Herdrich's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that Herdrich travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois. The "market forces" the dissent refers to hardly seem to have produced a positive result in this case—Herdrich suffered a life-threatening illness (peritonitis), which necessitated a longer hospital stay and more serious surgery at a greater cost to her and the Plan. And, as discussed below, we are far from alone in our belief that market forces are insufficient to cure the deleterious affects of managed care on the health care industry.

Across the country, health care critics and consumers are complaining that the quality of medical treatment in this nation is rapidly declining, leaving "a fear that the goal of managing care has been replaced by the goal of managing costs." Jan Greene, *Has Managed Care Lost Its Soul? Health*

⁹ Doctor Hyman Lans, Herdrich's medical expert, stated at his deposition that Herdrich's condition worsened during the eight-day waiting period "[b]ecause obviously there has been another week of the appendix becoming necrotic and sitting in the pus, and obviously the process has continued during that week and doesn't correct itself."

Maintenance Organizations Focus More on Finances, Less on Care, Am. Hosp. Publishing Inc., May 20, 1997.

An increasing number of Americans believe that dollars are more important than people in the evolving [HMO] system. Whether justified or not, this assumption needs to be taken seriously, according to keepers of the industry's conscience. University of Pennsylvania bioethicist Arthur Caplan argues that managed care should take a lesson from professional sports, which has alienated some fans because money and profits have eclipsed the reasons why fans care about the games; hero worship and the virtues of teamwork, loyalty and trustworthiness. The same goes for doctors. "People go to their doctor not because he's a good businessman . . . but because he's a good advocate, someone we can admire," says Caplan. "If we have to struggle with him to get what we want, we will have no trust anymore."

To regain trust, HMOs need to be more sensitive to the doctor-patient relationship and remove the physician from direct financial interest in patient care, says Caplan. Instead, doctors should have a predetermined budget and be able to advocate for patients without direct personal gain or loss.

Another hot-button issue for HMO members is the fear that a lifesaving experimental procedure will be denied because of its cost. Caplan says the industry should follow the lead of the handful of HMOs that have established outside, independent panels to make final decisions.

Id. Even care providers fear that they "have become somewhat preoccupied with [their] ownership status and consequently have not paid as much attention as [they] should have to improving [their] basic core competencies." *Id.* The specter of money concerns driving the health care system, says a group of Massachusetts physicians and nurses, "threaten[s] to transform healing from a covenant into a business contract. Canons of commerce are displacing dictates of healing, trampling our professions' most sacred values. Market medicine treats patients as profit centers." *For Our Patients, Not for Profits: A Call to Action*, JAMA, Dec. 3, 1997, at 1773. As one professional stated, "It's too bad. We used to spend most of our time worrying about how to do a better job. Now we worry about doing a better job at a lower price." *Id.*

Thousands of American physicians and nurses, outraged by the increasingly "corporate" nature of American medicine, recently staged a reenactment of the Boston Tea Party by symbolically dumping \$1 million each minute into Boston Harbor to dramatize the amount of health care money that is being wasted to pay for HMO marketing, profits, and administrative salaries. *See id.*

The shift to profit-driven care is at a gallop. For nurses and physicians, the space for good work in a bad system rapidly narrows. For the public, who are mostly healthy and use little care, awareness of the degradation of medicine builds slowly; it is mainly those who are expensively ill who encounter the dark side of market-driven health care. We criticize market medicine not to obscure or excuse the failings of the past, but to warn that the changes afoot push nursing and medicine farther from caring, fairness, and efficiency.

Id. Another commentator observed that "American 'market theology' is being invoked as an excuse for the downgrading of patient care and the growing absence of compassion in health care." Bob LeBow, *Nation Needs to Take Control of Health Care System for Patients, not Profits*, Idaho Statesman, Dec. 2, 1997, at 6A. Instead of providing health care, doctors are forced to "spend many hours persuading health insurance companies that we are to trying to manipulate them into paying more money than Medicare does for kidney transplants." Gabriel M. Danovitch, et al., *And How the Decisions Are Made*, 331 New Eng. J. Med., at 331-32 (1984).

In order to minimize health care costs and fatten corporate profits for HMOs, primary care physicians face severe restrictions on referrals and diagnostic tests, and at the same time, must contend with ever-shrinking incomes.

Sixty percent of all managed-care plans, including HMOs and preferred-provider organizations, now pay their primary-care doctors through some sort of "capitation" system, according to the Physician Payment Review Commission in Washington, D.C. That is, rather than simply pay any bill presented to them by your doctor, most HMOs pay their physicians a set amount every month—a fee for including you among their patients. At Chicago's GIA Primary Care Network, for instance, physicians get \$8.43 each month for every male patient . . . and \$10.09 for every female patient Some HMOs, such as Oxford Health Plans, Cigna and Aetna, have "withhold" systems, in which a percentage of the doctors' monthly fees are withheld and then reimbursed if they keep their

referral rates low enough. Others, like U.S. Healthcare, pay bonuses for low referral rates.

John Protos, *Ten Things Your HMO Won't Tell You*, Inside, June 30, 1997, at 44.

[T]here is ample evidence that the bottom line mentality is taking over. HMOs refer to the proportion of premiums they pay out for patient care as their "medical-loss ratio"—a chilling choice of words. The Association of American Medical Colleges reported last November that medical-loss ratios of for-profit HMOs paying a flat fee to doctors for treatment averaged only 70% of their premium revenue. The remaining 30% went for administrative expenses—and profit.

George J. Church, *Backlash Against HMOs*, Time, Apr. 14, 1997, at 32. Doctors, in accordance with bureaucracy-like HMO and government (*i.e.*, Medicare) reporting regulations, are often required to engage in countless hours of paper shuffling and file stacks of forms to complete even the most basic reimbursement claims. Moreover, the recent trends of sky-rocketing malpractice insurance rates has put additional stress on physicians and surgeons: certain specialists may spend 60 percent of their overhead costs on malpractice insurance, some obstetrician-gynecologists pay \$100,000 per year for coverage, and neurosurgeons or orthopaedic surgeons can pay in excess of \$100,000 per year. See Charles Krauthammer, *Driving the Best Doctors Away: Physicians are Getting Hammered by Managed Care Micromanagement and Malpractice Insurance Premiums*, Wash. Post, Jan. 9, 1998, at A21. In fact, many observers note that an increasing number of physicians are abandoning the profession because they are disenchanted with the notion of having "medically

ignorant administrators" dictate that they limit patient care so as to pad the pockets of the officers of insurance companies and HMO organizations. See *id.* "More than money, this is what is driving these senior doctors crazy: some 24-year-old HMO functionary who knows as much about medicine as he does about cartography demanding to know why Mr. Jones, the diabetic in renal failure, has not been discharged from the hospital yet." *Id.* Nor is the market serving the future of the practice of medicine well—the pool of applicants at our nation's medical schools seems to be drying up; many potential doctors cite increased costs and unpleasant, HMO-controlled working conditions as key factors driving the nation's aspiring surgeons away from the operating table. See Judith Graham, *Medical School Applicants Dip*, Chi. Trib., Feb. 1, 1998, at 1. Yet another consequence of the increase in HMO decision-making authority has been a dramatic rise in consumer disputes with HMOs. Last year, consumers in the State of Wisconsin filed nearly 5,000 grievances against Wisconsin HMOs, almost a third more than in 1986. Of these 5,000 grievances, HMOs reversed their care decisions in 68 percent of complaints. *News From Every State*, USA Today, June 4, 1998, at 10A.

Many physicians, frustrated with the cost pressures of managed care, including those attributable to unnecessary HMO, insurance company, and governmental regulations, have attempted to counter the influence of large, regional health care providers by organizing into unions. See *Doctors Seeking to Unionize: A Remedy?*, Chi. Trib., Feb. 1, 1998, at 10. Collective bargaining provides unionized doctors with the ability to wield greater leverage when faced with an HMO's efforts to reduce physicians' incomes. See *id.* Doctors who are dissatisfied with the corporate, profit-driven nature of HMOs, as well as the loss of independence in the doctor-patient relationship, are also considering competing head-on

and are forming their own HMOs, just as was done here. Many of these physicians and surgeons have joined their respective specialty practices and linked up with local hospitals to compete with regional HMOs for managed care contracts. But in these circumstances, as in our case, doctors often assume the dual role of care-provider and HMO administrator, and are ultimately held accountable for breaches of fiduciary duty.

This court has previously addressed the cost-saving pressures currently being exerted on medical-care providers. In *State of Wis., Dep't. of Health and Soc. Servs. v. Bowen*, 797 F.2d 391 (7th Cir. 1986), the author of this majority opinion addressed the Secretary of Health's control over Medicaid's patient care costs.

A nursing practitioner or physician's assistant is not adequately trained to make the all-important decision dealing with levels of care. It is shocking in our day of advanced medical research, techniques and surgery, when organ transplants and space medicine research are routinely-accepted medical procedures, that we seem to be forgetting and casting aside the all-important human and personal element in medical care. It is equally shocking that we are in effect turning the medical transfer decisions over to the paper shuffling bureaucrat for a review of an inadequately trained medical support assistant. Nursing practitioners and physician's assistants are incapable of making this life-threatening judgment, because they lack both the personal contact with the patient and his family over a period of time, and most frequently lack the necessary expertise, training and experience in psychology, psychiatry and geriatrics

required to properly interpret and knowledgeably assess the dangers of transfer trauma.

Id. at 410 (Coffey, J., dissenting).¹⁰

We must remember that doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients. Trained physicians, and them alone, should be allowed to make care-related decisions (with, of course, input from the patient). Medical care should not be subject to the whim of the new layer of insurance bureaucracy now dictating the most basic, as well as the important, medical policies and procedures from the boardroom. If it is, "the cost cutting of managed health organizations and insurers may undermine what is, for now, the best medical care in the world." Joan Beck, "*Drive-by Deliveries*" *Risky Health Game*, Hous. Chron., Oct. 28, 1995, at 36. It shall also place physicians in a more severe conundrum, forcing them to limit the costs associated with nature and duration of treatment while, at the same time, attempting to avoid the liability of a medical malpractice suit.

¹⁰ In *Bowen*, the United States Department of Health and Human Services sued the state of Wisconsin, alleging that the state's of administering Medicaid care was not in strict compliance with federal requirements. See *id.* at 392-93. As a result, the Department disallowed several reimbursements for the state's Medicaid expenditure. See *id.* at 393. The state responded that the Wisconsin system saved money and was in the best interest of its citizens. See *id.* at 394. Although the majority opinion supported the Department of Health and Human Services, the state's petition for certiorari was granted. See 479 U.S. 1053, 107 S. Ct. 926, 93 L. Ed.2d 978 (1987). However, a few days prior to oral argument before the Supreme Court, the Department settled with the state, thereby avoiding further consideration of the issue.

A response to the crisis in market-based care has come to roost in Washington, D.C., as a result of constituent sentiment from across the country. Legislation has been introduced that would place restraints on HMOs, provide a "bill of rights"¹¹ to unhappy health care consumers, and even extend to HMO participants the power to individually sue their health plans for damages. See Laura Litvan, *Has Managed Care Hurt Quality?*, Investors Bus. Daily, May 1, 1998, at A1. This ability to sue may possibly serve in some measure to rectify the troubling state of affairs which currently exists, where patients can be without a remedy for medical malpractice. See Jamie Court, *Holding HMOs Accountable for their Egregious Conduct*, Chi. Trib., June 22, 1998, at 13 ("HMOs overturn doctors' decisions, deny treatment and then claim in court that they don't practice medicine, only provide coverage, so that HMOs cannot be sued for medical malpractice"). These proposals are still being debated in the committee hearing stage of the legislative process, and as yet have not been enacted to control the accelerated decline of our health care system.

Along the same lines as its "market forces" argument, the dissent submits that the defendants' plan "encourag[ed] physicians to use resources more efficiently." Although we agree, at least in principle, with the idea that financial incentives may very well bring about a more effective use of plan assets, we certainly are far from confident that it was at work in this

¹¹ Indeed, many Americans view health care as a right: "Although the U.S. has currently opted for a market-based health care system, the public has shown by the recurrent eruptions of outrage that it views health care as a social good, and even a right, not a commodity." Greene, *supra* at p.375. While health care may not in fact be a right, the doctor's decision-making authority when administering treatment should not be cast asunder by an insurance company's mandate on physicians that monetary concerns be placed above the quality of care, especially in those case where the doctor is not even required to apprise the patient of more effective, but more expensive, options.

particular case. The Carle health plan at issue was not used as efficiently as it should have been. Indeed, the eight-day delay in medical care, and the onset of peritonitis Herdrich incurred as a result of such delay in diagnosis, subjected her to a life-threatening illness, a longer period of hospitalization and treatment, more extensive, invasive and dangerous surgery, increased hospitalization costs, and a greater ingestion of prescription drugs.

The dissent also somehow contends that "ERISA tolerates some conflict of interest on the part of fiduciaries," and therefore, "allowing a plan sponsor to designate its own agent as a fiduciary reassures the sponsor that, in devoting its assets to the plan, it has not relinquished all ability to ensure that the plan's resources are used wisely." In so doing, the dissent relies on two cases from this circuit, *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340 (7th Cir. 1995), and *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998). In *Chalmers*, the plaintiff, Chalmers, a former officer of the defendant Quaker Oats Company, brought an ERISA action against the severance pay program of his former employer. See 61 F.3d at 1342. Chalmers challenged his denial of severance benefits, arguing that the program's severance committee's ruling should be reversed because its members, who were all officers of the Quaker Oats Company, operated under a conflict of interest. See *id.* at 1344. We held that an automatic bias did not exist against the distribution of severance benefits, in spite of the fact that the members of the severance benefit distribution committee were officers of the corporation. See *id.*

Similarly, in *Mers*, Dale Mers worked for the defendant Marriott International, Inc. and was a member of Marriott's accidental death and dismemberment insurance plan. See 144 F.3d at 1017-18. While participating in a company-sponsored

volunteer project, he suffered a heart attack, fell to the ground, and expired a short time thereafter. Mers' wife, Pamela, submitted a proof of claim under the plan. In order to have qualified to receive benefits under Marriott's plan, the decedent's "injury" had to have been caused by the "accident." *See id.* at 1018-19. The plan insurer, American International Group ("AIG"), was given dual authority to serve both as plan insurer and the decision-maker in determining which claims qualified for payment. AIG denied Pamela the benefits she was seeking because, among other reasons, "the definition of injury found in the policies and the disease exception in ... [the] policy did not cover Dale Mers' death" and, in its view, "an accident did not cause his death." *Id.* at 1018-19. Pamela filed a complaint asserting that Marriott wrongfully denied her claim, in violation of sections 502(a)(1)(B) and 1132(a)(1)(B) of ERISA. The district court, in granting the plan's motion for summary judgment, found that, although AIG's dual-role caused the insurer to operate under an inherent conflict of interest, the plan's denial of benefits was reasonable to the extent that Dale Mers' death was not an "injury" under the terms of the plan. *See id.* at 1019. We affirmed in *Mers*, but concluded that "no conflict of interest exists because paying meritorious claims is in AIG's best interest," that is, it would harm AIG in the long run to consistently deny valid claims "by inducing current customers to leave and by damaging its chances of acquiring new customers." *Id.* at 1020-21.

In considering our decisions in *Mers* and *Chalmers*, it is important to note that this court has heretofore not been called upon to address the situation where each and every member of the benefit plan's administrative review board were the very owners of the plan, and plan beneficiaries were without a single representative on the board. In our view, *Chalmers* and its ilk are distinguishable from the facts in this appeal because, whereas the members of the Quaker severance committee were

all officers of Quaker, not one of the officers was an "owner" of, or had a direct financial interest in, the Quaker Oats Company, as was the case here. According to the record before us, the doctors who owned Carle and provided medical care to plan beneficiaries were the very same individuals who served as officers and directors of HAMP, the plan-administrating subsidiary of Carle. As the plaintiff alleged in her complaint, it is more likely than not that an incentive existed for the Carle doctors to abuse the dual loyalties that they observed in administering the Plan by "minimiz[ing] the use of diagnostic tests[,] ... the use of facilities not owned by CARLE[,] ... and the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians."

The dissent implies that Herdrich's claim of breach should fail because, in *Chalmers*, we held that the severance benefits paid by Quaker officers, which were distributed from corporate earnings, did not give rise to a claim for breach of fiduciary duty. As this Court noted in *Chalmers*, "[Quaker] is a corporation which generates revenues of nearly \$6 billion annually and is therefore not likely to flinch at paying out \$240,000 [the amount in question in the *Chalmers* case]." 61 F.3d at 1344. The dissent attempts to liken the benefits distribution scheme in *Chalmers* to the one in this case by quoting the following language from *Chalmers*: "[I]t is also a poor business decision to make it a practice of resisting claims for benefits. In the long run, such a practice would dampen loyalties of current employees while hindering attempts to attract new talent." *Id.* Importantly, however, the officers in *Chalmers* who made the decision to distribute severance benefits were not the owners of the corporation. In fact, nothing in the facts of *Chalmers* leads us to infer that Quaker officers were shareholders, or even had an interest in the financial well-being of the company. Moreover, it is somewhat misleading to compare a \$6 billion corporate entity like Quaker

with HAMP, which holds less than \$14 million in assets.¹² A doctor who is responsible for the real-life financial demands of providing for his or her family—sending four children to school (whether it be college, high school or primary school), making house payments, covering office overhead, and paying malpractice insurance—might very well "flinch" at the prospect of obtaining a relatively substantial bonus for himself or herself. *Here, the Carle physicians were intimately involved with the financial well-being of the enterprise in that the yearly "kick-back" was paid to Carle physicians only if the annual expenditure made by physicians on benefits was less than total plan receipts. According to the complaint, Carle doctors stood to gain financially when they were able to limit treatments and referrals.* Due to the dual-loyalties at work, Carle doctors were faced with an incentive to limit costs so as to guarantee a greater kickback. In *Chalmers*, by comparison, the drain on profits resulting from a payout of benefits had no direct link at all to the officers' annual salaries.

In summary, we hold that the language of the plaintiff's complaint is sufficient in alleging that the defendants' incentive system depleted plan resources so as to benefit physicians who, coincidentally, administered the Plan, possibly to the detriment of their patients. The ultimate determination of whether the defendants violated their fiduciary obligations to act solely in the interest of the Plan participants and beneficiaries, *see* 29 U.S.C. § 1104(a)(1), must be left to the trial court. On the surface, it does not appear to use that it was in the interest of plan participants for the defendants to deplete the Plan's funds by way of year-end bonus payouts. Based on the record we have

¹² While the record does not reflect exactly what HAMP's assets are, as of December 31, 1992, its largest affiliate and/or subsidiary corporation had assets totaling \$13,847,000, which were admittedly more than HAMP's.

before us, we hold that the plaintiff has alleged sufficiently a breach of the defendants' fiduciary duty.

3. Loss to Plan

Finally, the defendants argue that Herdrich's claim must be dismissed because she does not allege that she suffered any loss attributable to the defendants' disputed breach. Specifically, they contend that beneficiaries in an ERISA plan may not recover anything other than the benefits provided expressly in the Plan itself. This is a mischaracterization of the law as it stands in this circuit.

ERISA allows any plan beneficiary to sue any plan fiduciary for breach of fiduciary duty. "Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by [ERISA] shall be personally liable to make good to such plan any losses to the plan resulting from each such breach" 29 U.S.C. § 1109(a). Furthermore:

A civil action may be brought—

- (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan

Id. at § 1132(a). "There can be no disagreement . . . that § [1132(a)] authorizes a beneficiary to bring an action against a fiduciary who has violated § [1109]." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140, 105 S.Ct. 3085, 3089, 87 L.Ed.2d 96 (1985). ERISA's "draftsmen were

primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary." *Id.* 473 U.S. at 142, 105 S.Ct. at 3090 (footnote omitted). In such suits, plan beneficiaries have standing to bring an action on behalf of the plan itself to recoup monies expended in violation of ERISA, as the plaintiff has done here. See 29 U.S.C. § 1132(a). "[T]he fiduciary duties set forth in § [1109] run only to the plan, and not to individual beneficiaries." *Harsch v. Eisenberg*, 956 F.2d 651, 657 (7th Cir. 1992) (citation and internal quotation omitted). In paragraph 13 of her complaint, Herdrich alleges that as a result of the defendants' actions, the Plan was deprived of the supplemental medical expense payment amounts in controversy. We thus hold that she has alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants' actions.

IV. CONCLUSION

We conclude that this court has jurisdiction to consider Herdrich's appeal and that the trial judge erred in dismissing the plaintiff's amended count III against the defendants for breach of fiduciary duty under ERISA. We reverse the district court's order dismissing the plaintiff's amended count III and remand for further proceedings consistent with this opinion.

REVERSED.

FLAUM, Circuit Judge, dissenting.

This is a case of first impression in which the plaintiff alleges that the imposition of financial incentives designed to limit the provision of health care benefits constitutes a breach of fiduciary duty under ERISA. The plaintiff's complaint alleges that there is a conflict of interest built into the compensation

structure of the health plan in question. I fully accept the Majority's conclusion that, taking the allegations of the complaint as true, "an incentive existed for [the defendants] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses." Maj. Op. at 372. I disagree with the Majority's holding, however, that the mere existence of this asserted conflict, without more, gives rise to a cause of action for breach of fiduciary duty under ERISA. I respectfully dissent.

As described in the complaint, the defendants occupy two different roles in the health plan. The defendants are the plan's doctors, who provide medical care to the plan beneficiaries, and they are also the plan administrators, who (as fiduciaries) make decisions about what claims and conditions are covered under the plan. The complaint alleges that the defendants have breached their fiduciary duty in two ways. First, according to the complaint, the defendants have hired CARLE owner/physicians (*i.e.*, themselves) to provide medical services under the plan while cutting costs by minimizing the resources expended on each patient. By minimizing these expenditures, the defendants preserve funds to be distributed to themselves as year-end bonuses. Second, the complaint alleges that the defendants have administered disputed and non-routine claims. Again, the implication is that these claims are administered with an eye towards denying these claims to augment the defendants' year-end bonuses. Thus, the complaint alleges a structural incentive to deny care both at the point of delivery (*i.e.*, the treatment decision affecting patient care) and at the point of entry (*i.e.*, the coverage decisions). In my view, however, merely pointing out the existence of these structural incentives does not suffice to make out a cause of action for breach of fiduciary duty under ERISA.

Consider first the defendants' alleged incentive to deny coverage in disputed and non-routine claims. Based on the

allegations in the complaint, there is indeed an incentive to deny claims and thereby maintain large year-end bonuses. Unlike the common law of trusts, however, which is merely the baseline for determining the scope of fiduciary duty under ERISA, see *Varity Corp. v. Howe*, 516 U.S. 489, 496-97, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996), ERISA tolerates some conflict of interest on the part of fiduciaries. Most notably, section 408(c)(3) of ERISA permits an employer or other plan sponsor to have its own "officer, employee, agent, or other representative" serve as trustee or other fiduciary. 29 U.S.C. § 1108(c)(3). See *Donovan v. Bierwirth*, 538 F.Supp. 463, 468 (E.D.N.Y.1981) (describing § 408(c)(3) as "an unorthodox departure from the common law rule against dual loyalties"). One justification for this departure from the common-law tradition is that allowing a plan sponsor to designate its own agent as a fiduciary reassures the sponsor that, in devoting its assets to the plan, it has not relinquished all ability to ensure that the plan's resources are used wisely. This reassurance in turn encourages more employers and other sponsors to establish benefits plans. See Daniel Fischel & John Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L.REV. 1105, 112728 (1988). Although the dual loyalty ascribed to the defendants in this case is not identical to the conflict experienced by a fiduciary who is also the sponsor's agent, section 408(c)(3) demonstrates that dual loyalties are not *per se* unlawful under ERISA.

Moreover, we have recognized in a related context that market forces help reduce the risk that the fiduciary's conflict of interest in making coverage decisions will work to the detriment of the plan and the plan beneficiaries. In reviewing denials of benefits under section 502(a)(1)(B) of ERISA, we are often confronted with situations in which the plan administrator had a financial incentive to deny claims. For instance, in *Chalmers v. Quaker Oats Company*, 61 F.3d 1340 (7th Cir.1995), the

plaintiff argued that corporate officers who served on the plan administration committee had an automatic bias against dispensing severance benefits because those benefits would be paid directly from the corporation's earnings. *Id.* at 1344. In rejecting the plaintiff's claim of bias, we explained that "it is a poor business decision to make it a practice of resisting claims for benefits. In the long run, such a practice would dampen loyalties of current employees while hindering attempts to attract new talent." *Id.*; see also *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1051 (7th Cir. 1987). We have recently expanded on this rationale in finding that no conflict of interest existed when an insurer serving as a plan administrator denied a claim that, if it had been approved, would have been paid out of the insurer's assets:

[I]t is a poor business decision to resist paying meritorious claims for benefits. Companies ... that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans [T]hese employers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer ... consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers. Thus, no conflict of interest exists because paying meritorious claims is in [the insurer's] best interest.

Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020-21 (7th Cir. 1998).

The reasoning regarding conflicts of interest in the denial of benefits context applies with equal force to the plaintiff's claim of breach of fiduciary duty. The sponsor of the plaintiff's plan, State Farm, is a sophisticated, experienced player in the market for health benefits. The defendants do have a financial interest in denying coverage, just as the corporation did in *Chalmers* and the insurer did in *Mers*. But State Farm has an interest in ensuring that its employees are satisfied with their fringe benefits, and the defendants have an interest in ensuring that State Farm is satisfied with the defendants' performance in delivering health care to the beneficiaries. In this sense, the interests of the administrator align with the interests of beneficiaries and the sponsor. I recognize, of course, that monitoring of plan administrators by sponsors and beneficiaries is sometimes imperfect, and there is no guarantee that a sponsor will be able to find satisfactory alternatives in the marketplace. The plaintiff's complaint, however, alleges only that an incentive to deny coverage exists, which in my view is not enough to support an inference that market forces have failed in this case to protect the interests of beneficiaries.

The complaint's second allegation of breach of fiduciary duty, alleging an incentive to deny care at the point of delivery, also fails to state a claim upon which relief may be granted. As the Majority points out, such incentives are increasingly common in the age of managed care. Although the Majority identifies the potential pitfalls of managed care plans, see Maj. Op. at 374-77, there are also benefits to such plans that nevertheless make them attractive to many sponsors and beneficiaries of ERISA plans.¹ Since many sponsors and

¹ The goal of managed care plan is to deliver health care more cost-effectively by eliminating unnecessary or ineffective treatments and providing necessary care more efficiently. Some plans, like the one addressed in this case, attempt

(continued...)

beneficiaries of managed care plans view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently, merely alleging the existence of financial incentives to limit care cannot suffice to make out a claim of breach of fiduciary duty.

The complaint could be ready to imply, however, that the defendants' incentives to limit care are so high that they work to the detriment of the plan and plan beneficiaries. When health plans provide physicians with incentives to internalize costs and maximize efficiency, as appears to be the case here,

¹ (...continued)

to achieve these goals by introducing incentives that encourage physicians to internalize part of the costs of treatment. (According to the complaint, the instant plan contains a bonus structure that makes the physician's income depend in part on how efficiently the physician delivers care by minimizing expenditure of resources.) Other plans try to achieve efficiency goals by implementing utilization review procedures, in which the treating physician must obtain from the insurer advance approval of patient-care decisions. This method also has its drawbacks, especially when the reviewer lacks the medical expertise of the treating physician. See generally E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment*, 1 WIDENER L. SYMP. J. 89, 91-95 (1996) (describing the variety of cost-containment techniques employed by managed care plans).

Of course, the desirability of these different cost-containment measures from a policy standpoint is not our concern. But in assessing the plaintiff's assertion that incentives alone constitute a breach of fiduciary duty, it is worth noting that some commentators defend the use of financial incentives as a superior alternative to utilization review by insurers. By removing the insurer as an intermediary in patient care decisions, financial incentives can give physicians greater clinical autonomy (provided that the incentives are set at an appropriate level) and may lead to better decisions about how to reduce costs while maintaining quality. See Frances H. Miller, *Capitation & Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma?* 6 HEALTH MATRIX 89, 97-99 (1996); David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 173-77 (1996).

there is a serious concern that patient care will suffer if the incentives to limit care are set too high. The task of identifying appropriate limits for incentives is an important item on the legislative and regulatory agenda. See, e.g., 42 U.S.C. § 1395mm(i)(8) (regulating the use of financial incentives by health care plans treating Medicare and Medicaid recipients); 42 C.F.R. § 417.479 (same); Edward B. Hirshfeld, *Provider Sponsored Organizations and Provider Service Networks—Rationale and Regulation*, 22 AM. J.L. & MED. 263 (1996) (discussing avenues for regulating provider sponsored organizations, or PSOs, which are physician groups that bear investment and insurance risk with respect to the delivery of health care services). If the complaint is indeed asserting that the incentives in this case are excessive, then the plaintiffs in effect are inviting the court to make its own determination about appropriate incentive levels in managed care.

In reversing the dismissal of the plaintiff's complaint, the Majority appears to accept the invitation. In my view, however, judicial efforts to determine permissible levels of financial incentives through the vehicle of ERISA's fiduciary rules are unnecessary and ill-advised. No standards for conducting such an inquiry exist. Such a move would preempt legislative and regulatory efforts in this area and could seriously disrupt the ability of plan sponsors and beneficiaries to manage plan assets by agreeing to incentives that encourage cost-conscious medical decisionmaking. The Majority's decision provides little guidance for the district court on remand, and I fear that the decision today could lead, both in this case and in the future, to untethered judicial assessments of permissible incentive levels in health care plans.

Although I cannot join the Majority's decision in this case, I share the Majority's concern about the possibility of incentives that may harm plan beneficiaries, and I believe that

courts have a role in ensuring that incentives are implemented in accordance with the fiduciary duties imposed by ERISA. In my judgment, this role is triggered when the market fails to ensure that the interests of sponsors, administrators, and beneficiaries are in alignment. As noted above, plan sponsors are likely to take their business elsewhere if they perceive that incentives are working to the detriment of beneficiaries or the plan itself, and thus market forces go a long way towards ensuring that incentives do not rise to dangerous or undesirable levels. In order for the market to function in this context, however, sponsors and beneficiaries need information about the financial incentives that are in place. Thus, I would follow the Eighth Circuit's lead in holding that the failure to disclose financial incentives is a breach of fiduciary duty under ERISA. See *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997), *cert. denied*,—U.S.—, 118 S.Ct. 297, 139 L.Ed.2d 229 (1997).²

Until the Majority's expansion of liability in today case, *Shea* stood at the frontier in terms of imposing liability under ERISA on health plans that seek to control costs by providing financial incentives to limit patient care. The *Shea* decision has

² The Majority relies on *Shea* and another decision, *Ries v. Humana Health Plan, Inc.*, No. 94 C 6180, 1995 WL 669583 (N.D.Ill. Nov. 8, 1995), in reversing the dismissal of the plaintiff's complaint. See Maj. Op. at 372-73. I do not believe that these cases aid the plaintiff. In both cases, there was a breach of fiduciary duty because the health plan failed to disclose to plan beneficiaries the existence of financial arrangements between the plan and health care providers that allegedly operated to the detriment of the beneficiaries. See *Shea*, 107 F.3d at 628; *Ries*, 1995 WL 669583 at *2, *7. The complaint in the instant case, however, never asserts that the plaintiff's health plan failed to disclose the financial incentives under which its physicians were operating. Thus, these disclosure cases are inapposite to the plaintiff's theory, which appears to be that the mere existence of such incentives (or, at least, incentives that a court might feel are excessive) constitutes a breach of fiduciary duty.

proven to be controversial. See, e.g., *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 754-55 (S.D.N.Y.1997) (rejecting *Shea* and holding that there is no fiduciary duty under ERISA to disclose financial incentives to limit care); see also "Full Disclosure," ERISA LITIGATION REPORTER, April 1997 at 3 (describing *Shea* as "a decision that has been getting a lot of notice" and as a "far-reaching example" of "the expansion of disclosure duties into non-benefits contexts"). The Second Circuit has obliquely adopted *Shea's* rationale, however, in a decision upholding the denial of a motion for preliminary injunction. See *Maltz v. Aetna Health Plans*, 114 F.3d 9, 11-12 (2d Cir.1997). The health plan at issue in *Maltz* had been paying its participating physicians on a fee-for-service basis. When the health plan decided to switch to a capitation method of payment—which created a financial incentive to limit care by paying the physician a flat monthly fee for each enrollee on his or her list—the plaintiff-beneficiary sued for a breach of fiduciary duty under ERISA. The Second Circuit held that the plaintiff failed to demonstrate irreparable harm or a likelihood of success on the merits:

[We] certainly acknowledge that incentive programs may affect the decisions physicians make in the treatment of their patients. Nothing in the contract between Aetna and its enrollees, however, limits Aetna's ability to make significant changes in its relationship with its doctors as long as the enrollees are aware of the changes when they renew their contract with Aetna and Aetna provides them with competent, alternative physicians Maltz renewed her contract with Aetna with full knowledge of these significant changes.

Id. at 12. Although the posture of *Maltz* as a preliminary injunction case makes it difficult to discern how the court would

ultimately rule on the merits, the *Maltz* opinion suggests at least a tentative acceptance of *Shea's* holding that nondisclosure of financial incentives to limit care may constitute a breach of fiduciary duty under ERISA.

Even when disclosures have been made, I would not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty when there is a serious flaw in the manner in which the incentive arrangement is established or a significant limitation on the ability of plan sponsors to obtain alternative arrangements in the market. Such a claim would have to make some allegation, which the plaintiffs in the instant case do not, pointing to special circumstances suggesting a breakdown in the market or in the negotiating process that led to the imposition of incentives. The complaint in this case, however, contains no allegation of nondisclosure, and it fails to make any allegations suggesting that the financial incentives to limit care are anything but the result of the bargain fairly struck between the plan's sponsor, administrator, and beneficiaries. I would affirm the decision below dismissing the complaint.

APPENDIX B

In the
United States Court of Appeals
For the Seventh Circuit

No. 97-10170

Cynthia Herdrich,

Plaintiff-Appellant,

v.

Lori Pegram, M.D., Carle Clinic Association,
and Health Alliance Medical Plans, Incorporated,

Defendants-Appellees.

On Petition for Rehearing and
Suggestion for Rehearing En Banc.

Decided March 8, 1999

Before Posner, Chief Judge, and Cummings, Harlington
Wood, Jr., Coffey, Flaum, Easterbrook, Ripple, Manion,
Kanne, Rovner, Diane P. Wood and Evans, Circuit Judges.

The case is before the court on a petition for rehearing
and suggestion for rehearing en banc filed by the defendants-

appellees. On consideration of the petition for rehearing and suggestion for rehearing en banc, a vote of the active members of the court was requested. A majority did not favor rehearing en banc. Chief Judge Posner and Circuit Judges Flaum, Easterbrook and Diane P. Wood voted to grant rehearing en banc. A majority of the judges on the original panel voted to deny rehearing en banc.

Accordingly, IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

Easterbrook, Circuit Judge, with whom Posner, Chief Judge, and Flaum and Diane P. Wood, Circuit Judges, join, dissenting from the denial of rehearing en banc.

Physicians employed by Carle Clinic Association, a health maintenance organization (HMO), failed to diagnose Cynthia Herdrich's appendicitis before her appendix ruptured. Peritonitis ensued, and Herdrich has recovered \$35,000 in damages for medical malpractice. She wants more, contending that Carle is a "fiduciary" under ERISA because her husband's employer State Farm Insurance Companies provided Carle's plan as a fringe benefit (making it a "welfare benefit plan" under ERISA), and that the divided loyalties at the core of an HMO structure are forbidden by ERISA. Like other HMO systems, Carle collects in advance for a period of care. The less medical services cost, the more an HMO's owners (here, Carle's physicians) have left as profit at the end of the period. According to the panel, this violates 29 U.S.C. § 1104(a)(1)(A).

Like any business, Carle seeks to hold down its costs. Like most other HMOs, Carle does this through devices that have come to be called "managed care." For example, subscribers must receive their medical care from Carle's own physicians if that is at all possible. Herdrich contends that this

rule is responsible for her peritonitis: after finding an inflamed mass in her abdomen, a Carle physician scheduled her for an ultrasound examination eight days later at a Carle facility in Urbana, Illinois, rather than arranging for a local hospital in Bloomington to perform that examination immediately. That delay, the jury found in the malpractice case, led to the peritonitis.

When participants in an HMO plan sought to apply the "fraud" label to the money-saving incentive that characterizes the HMO form of organization, we replied that the details of HMO incentives need not be specifically explained to participants in ERISA plans. *Anderson v. Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994). The HMO structure differs substantially from traditional fee-for-service medicine in giving the HMO an incentive to skimp on care once an illness is discovered. It is equally true that the HMO system creates an inducement to keep the subscribers healthy as long as possible. An HMO makes its profit from healthy subscribers and thus provides ample preventive and diagnostic care, while many fee-for-service physicians make their living from sick or injured persons. If the HMO creates an incentive to provide too little care once a subscriber becomes seriously ill, the fee-for-service system coupled with insurance provides an incentive to furnish excessive care, for third parties foot the bill. A choice between prepaid and fee-for-service systems is accordingly difficult to make in principle.

What I find troubling about the panel opinion, and why I believe this case should be reheard en banc, is that the panel has condemned HMO and managed-care systems on medical grounds, 154 F.3d 362, 373-79 (7th Cir. 1998), and used its view of good medical practice as the basis of a conclusion that the HMO structure violates ERISA. According to the panel, market forces do not constrain the pernicious incentives that

HMOs adopt, and it is accordingly necessary to throw the weight of the law behind traditional fee-for-service medicine. *Id.* at 374-75 ("market forces are insufficient to cure the deleterious affects [sic] of managed care on the health care industry"). This aspect of the panel's approach is almost a 180° turn from what we wrote in *Anderson*, a case the panel did not cite:

A health maintenance organization (HMO) offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, charge for each procedure. Each method creates an unfortunate incentive: a physician receiving a fee for each service has an incentive to run up the bill by furnishing unnecessary care, and an HMO has an incentive to skimp on care (once patients have signed up and paid) in order to save costs. Each incentive encounters countervailing forces: patients, or insurers on their behalf, resist paying the bills for unnecessary services, and HMOs must afford adequate care if they are to attract patients. HMOs also have a reason to deliver excellent preventive medicine. Prevention may reduce the need for costly services later. Competition among the many providers of health care, and between the principal methods of charging for that care, affords additional protection to consumers.

24 F.3d at 890. But let this pass, and suppose that HMOs and other managed-care systems are inferior to available alternatives. Why does ERISA authorize a court to prescribe its view of the best system?

The answer, according to the panel, is that ERISA requires plan administrators to act as fiduciaries, while the HMO structure puts physicians at (financial) odds with their patients. HMOs are of course not unique in this regard; insurers likewise seek to minimize their outlays for medical care and employ managed-care devices to promote thrift. But I am willing to suppose that Carle did not act as Herdrich's "fiduciary" would have. It did not have to.

Under ERISA,

a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added). Carle does not manage the State Farm plan or control its assets, so the panel emphasized sub-(iii), concluding that Carle has "discretionary authority or discretionary responsibility in the administration of such plan." See 154 F.3d at 369-71. Discretionary authority is obvious; but does Carle exercise discretion "in the administration of [the] plan", or only in the provision of medical services? This is a fundamental divide, for fiduciary status under ERISA is not an all-or-none affair. A person is a fiduciary only "to the extent" that he does one of the listed things; many major exercises of discretion, such as selecting the plan's terms, are outside of ERISA's fiduciary duties, even

though the same person is a fiduciary when implementing the plan. See *Hughes Aircraft Co. v. Jacobson*, 199 S. Ct. 755 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *McNab v. General Motors Corp.*, 162 F.3d 959 (7th Cir. 1998); *Johnson v. Georgia-Pacific Corp.*, 19 F.3d 1184, 1188 (7th Cir. 1994). A surgeon exercises a great deal of discretion when deciding how (if at all) to perform an operation, but the fact that an ERISA welfare benefit plan pays for the medical procedure does not make the surgeon a "fiduciary" of the patient and convert all medical-malpractice claims to federal common law under ERISA in the process. What is true at the level of a medical professional is true at the level of a medical practice group such as Carle. Unless the group exercises, not discretion in the abstract, but discretion "in the administration of [the] plan", it is not a fiduciary under ERISA. Lori Pegram, a physician employed by Carle, scheduled Herdrich for an ultrasound examination in Urbana on one day rather than in Bloomington on another; that does not sound like an exercise of discretion "in the administration of [the] plan". Similarly Carle's decision to establish one set of cost-saving incentives rather than another is not an exercise of discretion "in the administration of [the] plan"; it is an exercise of managerial discretion in the administration of Carle's business.

Perhaps it would be possible to read "in the administration of [the] plan" broadly in order to catch all discretionary elements of the HMO structure, but why should courts do this? In order to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure (or that participants will select it from among options the plan offers)? The panel's opinion sounds very much like this is the objective: its lengthy condemnation of managed care, 154 F.3d at 373-79, otherwise is hard to understand. But ERISA does not tie the plan sponsor's hands on issues of plan design. An employer is free to offer an HMO as an option without objection on

fiduciary-duty grounds. *Hughes and Lockheed*, which put plan-design issues outside the scope of § 1002(21), establish this point. If it is lawful under ERISA for an employer to offer an HMO as a welfare benefit, then it must be lawful for the HMO itself to administer a managed-care system. *Boyle v. United Technologies Corp.*, 487 U.S. 500, 506-07 (1988), observed that collecting damages from manufacturers of military hardware would, as a practical matter, limit the military's design choices. Just so with ERISA: a plan sponsor's right to adopt an HMO plan as a benefit would not be worth anything if implementing the HMO itself violates ERISA. What the panel has held comes to the same thing—though by a different route—as saying that welfare-benefit plans have a fiduciary duty not to adopt HMO or other managed-care options. If alternatives such as fee-for-service medicine are more expensive, then plan sponsors will be inclined to offer less medical coverage, and participants may be worse off. Clearly the panel thinks that they will be better off, and perhaps they will be. But ERISA allows plan sponsors and participants to choose for themselves. An employer is entitled to offer the combination of fringe benefits that it is willing to pay for; it need not offer the best available medical (or other) services. By stretching the definition of a "fiduciary" under ERISA, the panel has effectively foreclosed a popular option for the delivery of medical care and taken the decision out of private hands, to which ERISA committed it.

If Carle described to State Farm the cost-reduction incentives used by its plan, and State Farm knowingly chose Carle over other providers, then we have a simple plan-design issue. It would defeat the employer's right to specify the benefits conferred by a plan if the dissatisfied employee could turn around and sue the person who delivered those benefits. The only proper question in a suit against a supplier is whether that person did what he promised. Nothing in the panel's

opinion suggests that Carle Clinic pulled a fast one on State Farm. Fiduciary duties are vital when contracts are incomplete, but when a contract fully specifies proper behavior, then even a full-fledged trustee need not (indeed, must not) depart from the contractual provisions that the settlor established. See John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 Yale L.J. 625, 657-69 (1995). Carle followed its contract with State Farm and with its subscribers; that is all ERISA requires.

Note the parallel to the fiduciary standard of diversification, to which the panel refers. 154 F.3d at 371-72. Managers of a plan's assets usually have a fiduciary duty to diversify their investments. Yet if the plan sponsor chooses a nondiversified strategy (for example, an employee stock ownership plan), then the trustee administering the ESOP need not diversify; one can't use a fiduciary duty to compel the trustee to disregard a decision consciously made by the sponsor. Even in the private law of trusts a fiduciary may implement the settlor's plan, despite features of that plan that a fiduciary could not adopt on its own (that is, without the settlor's consent). So if Carle is analogous to the trustee, then the settlor's (State Farm's) consent authorizes it to carry out the plan that the settlor approved.

Perhaps this issue boils down to a matter of characterization. If one conceives of particular medical services as the "benefits" under the plan, then Carle serves as the gatekeeper to those benefits, and handling claims for medical benefits defined by a plan is a fiduciary role under ERISA. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985). But if instead one conceives of the CarleCare HMO system as the benefit promised by the ERISA plan, then Carle is not a "fiduciary." It is just the supplier of medical care, like the surgeon discussed above. Which characterization is

best? Herdrich does not allege that State Farm hired Carle to administer a medical plan that offers defined medical procedures as benefits; she alleges, rather, that the benefit State Farm offered is the CarleCare HMO system. And, for reasons I have already discussed, to the extent there is uncertainty about the right way to characterize Carle's role, the court should prefer the characterization that preserves plan sponsors' (and participants') freedom of choice. That means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan. If the HMO system is the benefit, then Carle is not acting as a fiduciary.

The choice between these characterizations is important—more than enough to justify convening the full court. Most medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option. The panel's opinion thus implies that the principal organizational forms through which medical care is delivered today are unlawful. If this conclusion is correct, then the cost-saving achieved by managed care must be abandoned, and the cost of medical care will rise, perhaps substantially.

I recognize that my colleagues in the majority of the panel have expressed their holding as a conclusion about this specific complaint and have written that cost-reduction incentives are not necessarily automatic violations of fiduciary duty. 154 F.3d at 373. But a holding such as this is impossible to cabin, for the plan attacked in this case is an ordinary HMO.

Drawing parallels to the case under consideration, Herdrich sets forth, in the amended third count of her complaint, the intricacies of the defendants' incentive structure. The Plan dictated that the very same HMO

administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

154 F.3d at 372 (emphasis in original). If Carle's setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." Unlike some other HMOs, Carle is owned by its physicians, but I do not think that this makes a legal (or practical) difference. Physicians own much of the stock of HMOs organized as corporations or receive some of its profits as bonuses or salary increments; and no matter the HMO's internal organization, the benefit to a particular physician from a particular treatment decision is minuscule. The effect of holding down costs can be large in the aggregate, but

this is so whether the HMO is organized as a corporation or as a partnership. Indeed, it is so whether the organization is an HMO or a law firm. Lawyers owe fiduciary duties to their clients. Can it be that the incentive given by the partnership's reward structure to substitute the services of associates for those of the partners creates a conflict of interest that invariably violates those duties? If the answer is "no" for law firms (and that must be the right answer), it is "no" for HMOs, in stock or partnership form.

Even if all of this is wrong, however, the panel's opinion puts all managed-care systems at risk and commits the court to a long (and I should think unhappy) course of distinguishing "good" managed-care systems from "bad" ones. Assessments of this kind belong to plan sponsors and participants, not to judges. Federal law both recognizes and regulates HMOs. *See* 42 U.S.C. § 300(e). It seems to me unwise and improper for a court to use ERISA to impress a different view of desirable medical care on employers and HMOs alike.

APPENDIX C

UNITED STATES DISTRICT COURT CENTRAL DISTRICT OF ILLINOIS

CYNTHIA HERDRICH,)	
)	
Plaintiff,)	
)	
v.)	Case No. 94-1143
)	
LORI PEGRAM, M.D., CARLE)	
CLINIC ASSOCIATION, and)	
HEALTH ALLIANCE MEDICAL)	
PLANS, INC.,)	
)	
Defendants.)	

ORDER

Before this Court is the Defendants' Motion to Dismiss [#34]. This matter was referred to the Magistrate Judge under Local Rule 1.4. On March 26, 1996, Magistrate Judge Robert J. Kauffman entered a Report & Recommendation granting the Motion. Pursuant to 28 U.S.C. § 636(b)(1), the parties had ten (10) working days after service of the Recommendation, until April 12, 1996, to file objections to the Magistrate's decision. Plaintiff, Cynthia Herdrich, filed a timely Objection to the Magistrate Judge's Report and Recommendation. On April 11, 1996, Defendants filed a Response to Herdrich's Objections.

After reviewing all relevant pleadings, this Court DENIES Herdrich's Objections to the Magistrate Judge's Report & Recommendation and ADOPTS the Report &

Recommendation in all respects. The Motion to Dismiss [#34] is allowed. Herdrich has twenty-one (21) days from the entry of this Order to replead her Count III ERISA claim. This matter is referred to Magistrate Judge Robert J. Kauffman for further proceedings.

Entered this 15th day of April, 1996.

/s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

APPENDIX D

UNITED STATES DISTRICT COURT CENTRAL DISTRICT OF ILLINOIS AT PEORIA

CYNTHIA HERDRICH)	
Plaintiff)	
)	
vs.)	Case No. 94-1143
)	
LORI PEGRAM, et al.)	
Defendant)	

REPORT & RECOMMENDATION

This is an action removed from state court on a federal question. Now before the court is the defendants' Motion to Dismiss Amended Count 3 (#34). The motion is fully briefed, and pursuant to Local Rule 1.4 the district judge has referred the matter to me for a report and recommendation. After carefully considering all of the submissions of the parties, and pursuant to 28 U.S.C. § 636(b)(1)(B), I recommend that the motion be allowed and the plaintiff be given one last chance to re-plead an ERISA claim.

The plaintiff originally filed a complaint in state court claiming medical negligence on the parts of defendants Pegram and Carle Clinic Association (Carle). She later amended her complaint to add two counts of fraud pursuant to state law against defendants Carle and Health Alliance Medical Plans, Inc. (HAMP). The defendants removed the entire case to federal court, asserting that the two new counts were preempted by ERISA (Employees Retirement Income Security Act of 1974,

29 U.S.C. § 1101, *et seq.*). The plaintiff moved to remand the case, arguing that ERISA did not apply to Counts 3 and 4. Chief Judge Mihm denied that motion in an order dated August 5, 1994. (#13).

Thereafter the defendants Carle and HAMP moved for summary judgment on Counts 3 and 4, arguing that they did not state a claim under ERISA. Chief Judge Mihm allowed the motion as to Count 4 and denied it as to Count 3, but ordered the plaintiff to re-plead Count 3 under ERISA. (#29).

On September 1, 1995 the plaintiff filed an Amended Count 3, naming as defendants Carle, HAMP and Carle Health Insurance Management Co., Inc. (CHIMCO) (#31). It is this amendment that the defendants now move to dismiss.

A complaint should not be dismissed unless it appears from the pleadings that the plaintiff could prove no set of facts in support of her claim which would entitle her to relief. *Conley v. Gibson*, 355 U.S. 41 (1957). For purposes of a motion to dismiss, the complaint is construed in the light most favorable to the plaintiff and its factual allegations are taken as true. *Scheuer v. Rhodes*, 416 U.S. 232 (1974). In addition, a complaint must contain either direct or inferential allegations respecting all the material elements necessary to sustain a recovery under some viable legal theory. *Sutliff, Inc. v. Donovan Cos.*, 727 F.2d 648 (7th Cir. 1984).

Amended Count 3 alleges that defendants Carle, HAMP, and CHIMCO have breached a fiduciary duty to the employee benefit plan under ERISA. The defendants move to dismiss arguing that Count 3 fails to state a claim under ERISA, and that the new claim is totally unrelated to the original claim for medical negligence.

Plan beneficiaries may sue any plan fiduciary for breach of fiduciary duty under ERISA, 29 U.S.C. § 1109(a). The complaint must allege facts identifying the defendants as fiduciaries and identifying the specific actions alleged to have breached the fiduciary duty. Merely repeating the statutory language will not state a claim, *Tybout v. Karr Barth Pension Admin., Inc.*, 819 F.Supp. 371 (D.Del. 1993). There is no ERISA action against a non-fiduciary, *Buckley Dement, Inc. v. Travelers*, 39 F.3d 784 (7th Cir. 1994). Any relief awarded flows to the plan. There is no monetary relief available to an individual plaintiff, *Massachusetts Mutual Life Ins v. Russell*, 105 S.Ct. 3085 (1985).

In the case at bar, amended Count 3 fails to state a claim under ERISA for breach of fiduciary duty. First, none of the defendants is even mentioned in the Subscription Agreement attached to the complaint. The plaintiff fails to identify how any of the defendants is involved as a fiduciary to the Plan. For example, it is very difficult to see how Carle Clinic could be a fiduciary. Amended Count 3 merely repeats the statutory language of § 1109(a) with regard to fiduciaries.

The plaintiff should be allowed one last opportunity to re-plead under ERISA.

Even if the plaintiff could plead breach of fiduciary duty under ERISA, the court is concerned that the ERISA claim (which is the only basis for federal jurisdiction) is completely different from the original claim for medical negligence. In attempting to plead under ERISA, the plaintiff appears to be attacking the basic structure of the HMO and its arrangements with the Carle Clinic physicians. The alleged breach of fiduciary duty appears to involve how Carle physicians are paid by the HMO. The remedy for breach of fiduciary duty is reimbursement to the Plan. It is difficult to see how this alleged

breach arises out of the same transaction or occurrence as the medical negligence, which is necessary for the court's assertion of jurisdiction over the non-federal malpractice claim. In addition, the discovery and proof required for the ERISA claim is new and totally different from the discovery and proof on the malpractice claim. If an ERISA claim can be pleaded, it may be appropriate to sever and remand the malpractice action.

Accordingly, I recommend that the Motion to Dismiss Amended Count 3 (#34) be ALLOWED and that the plaintiff be given one last chance to re-plead the ERISA claim within 10 days of the date of final disposition of this motion by the court. Failure to re-plead will result in remand of the state claims.

The parties are advised that any objection to this recommendation must be filed in writing with the clerk of this court within ten (10) working days after service of this recommendation. *See*, 28 U.S.C. § 636(b)(1). Failure to object will constitute a waiver of objections on appeal. *Video Views Inc. v. Studio 21, Ltd.*, 797 F.2d 538 (7th Cir. 1986); F.R.Civ.P. 72.

ENTER this 26th day of March, 1996.

/s/ Robert J. Kauffman
ROBERT J. KAUFFMAN
UNITED STATES MAGISTRATE JUDGE

APPENDIX E

UNITED STATES DISTRICT COURT CENTRAL DISTRICT OF ILLINOIS

CYNTHIA HERDRICH,)	
)	
Plaintiff,)	
)	
v.)	Case No. 94-1143
)	
LORI PEGRAM, M.D., CARLE)	
CLINIC ASSOCIATION, and)	
HEALTH ALLIANCE MEDICAL)	
PLANS, INC.,)	
)	
Defendants.)	

ORDER

Before the Court are Defendants' Motion for Summary Judgment [#16] and Plaintiff's Motion for Leave to File Amended Complaint [#22]. For the reasons set forth herein, the Motion for Summary Judgment is GRANTED in part and DENIED in part. The Motion for Leave to File Amended Complaint is GRANTED in part and DENIED in part.

Factual Background

Plaintiff filed a two count complaint in State court on October 21, 1992. Count I alleged medical negligence against Defendant Lori Pegram ("Pegram") for failing to adequately examine, treat, and follow-up on Plaintiff's complaint of right,

lower quadrant pain. She claims that Pegram's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II seeks to hold Carle Clinic Association ("Carle Clinic") liable under the theory of respondeat superior. Defendants Pegram and Carle Clinic filed an Answer to the State court complaint on December 8, 1992.

Herdrich filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("Health Alliance") in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq.* Count IV charges Health Alliance breached its duty of good faith and fair dealing. All of the Defendants filed a Notice of Removal with this Court on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Herdrich filed a Motion to Remand on April 8, 1994.

Her Motion to Remand argued that ERISA did not preempt Counts III and IV of her State court complaint because the State laws at issue did not relate to an employee benefit plan. Plaintiff asserted that Counts III and IV were merely related to employee benefits generally. ERISA's preemption provision provides, in relevant part,

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State law insofar as they may now or

hereafter relate to any employee benefit plan described in section 1003(a) of this title . . .

29 U.S.C. § 1144(a). She maintained that State law actions which are merely incidentally connected to an employee welfare benefit plan are not preempted by ERISA, citing *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 108 S.Ct. 2182 (1988). She concluded that Counts III and IV of her Complaint only indirectly affected the administration of a plan, in that her claims arose out Defendants business decisions and therefore were not preempted.

In opposition to the Motion to Remand, Defendants argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, Defendants set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. The factual synopsis also asserted that Defendant Health Alliance was the administrator and fiduciary of the Plan. Finally, Defendants contended that as part of the Plan, Health Alliance contracted with Carle Clinic to provide medical care to Plan participants in accordance with an agreed upon fee schedule. In response to Herdrich's legal argument that Count IV was not preempted because it lacked the necessary relationship to an employee benefit plan, Defendants maintained that Plaintiff's reference to the Plan and Health Alliance's duty in her Addendum to the Complaint evidenced a relation between Count IV and the employee welfare benefit plan.

On July 22, 1994, Magistrate Judge Robert J. Kauffman recommended the Motion to Remand be denied. (Report and Recommendation, at 1). The Magistrate Judge found that Count IV related to an employee welfare benefit plan, and as

such, was preempted by ERISA. *Id.* at 2-3. The Magistrate did not find specifically that Count III was preempted. Neither party filed objections to the Magistrate's Report and Recommendation, and this Court adopted the Magistrate's Report and Recommendation, denying the Motion to Remand on August 5, 1994.

Discussion

A motion for summary judgment will be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party has the responsibility of informing the court of portions of the record or affidavits that demonstrate the absence of a triable issue. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 2552 (1986). The moving party may meet its burden of showing an absence of material facts by demonstrating "that there is an absence of evidence to support the non-moving party's case." *Id.*, at 325, 106 S.Ct. at 2553. Any doubt as to the existence of a genuine issue for trial is resolved against the moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 2513 (1986); *Cain v. Lane*, 857 F.2d 1139, 1142 (7th Cir. 1988).

If the moving party meets its burden, the non-moving party then has the burden of presenting specific facts to show that there is a genuine issue of material fact. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S.Ct. 1348, 1355-56 (1986). Federal Rule of Civil Procedure 56(e) requires the non-moving party to go beyond the pleadings and produce evidence of a genuine issue for trial. *Celotex Corp.*, 477 U.S. at 324, 106 S.Ct. at 2553. This Court must then determine whether there is a need for trial—whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they

may be reasonably resolved in favor of either party. *Anderson*, 477 U.S. at 250, 106 S.Ct. at 2511.

Defendants submit that the Plan, through a subscription issued by Carle Clinic Health Maintenance Organization (Carle HMO), provided health and medical benefits to its participants and qualifies as an ERISA plan pursuant to 29 U.S.C. § 1001 *et seq.* Defendants assert that Plaintiff's contract with Health Alliance resulted solely from her enrollment in the Plan. Defendants contend, and Plaintiff does not deny, that all benefits provided for under the Plan were paid. Defendants state, without reference to supporting material, that Carle HMO acts as the fiduciary of the Plan. However, the Defendants also frame the issues contained in the Motion for Summary Judgment as "whether an ERISA plan participant/beneficiary may sue an ERISA plan fiduciary under Illinois common law and under the Illinois Consumer Fraud Act, 815 ILCS 505/1, *et seq.*, to recover extra-contractual damages," indicating that Carle Clinic and Health Alliance function as fiduciaries. This statement, taken in conjunction with the prior representations made by Defendants, indicates that there are three fiduciaries of the Plan: Carle Clinic, Health Alliance, and Carle HMO. Defendants' primary argument in support of its Motion for Summary Judgment, as to Count IV, is that regardless of who functions as the fiduciary, Plaintiff is not entitled to extracontractual damages under ERISA.

Herdrich claims that the Motion for Summary Judgment is "vague and ambiguous." She contends that Carle HMO is a product, not an entity and as such cannot qualify as a fiduciary under 29 U.S.C. § 1002(21)(A). She also submits that Carle Clinic is not a fiduciary as a matter of law and Defendants have failed to present evidence which supports their assertion that Carle Clinic is a fiduciary. Further, she argues that Health Alliance does not appear to be a fiduciary of the Plan as a

matter of fact. In support of this contention, Herdrich cites to Health Alliance's 1992 Annual Statement, filed with the Illinois Department of Insurance, which states that Health Alliance is not a "provider of administrative services or 'stop loss' group accident and health insurance to a multiple employer trust or multiple employer welfare arrangement." Herdrich submits that Carle Health Insurance Management Company ("CHIMCO") is, in fact, the fiduciary of the Plan. This Court will first address the issues raised by the parties in terms of Count IV, as neither the Magistrate Judge nor this Court have determined that Count III is preempted by ERISA. Then this Court will determine, for purposes of jurisdiction, whether Count III is preempted by ERISA.

A. *Count IV*

As there are serious questions about which organization(s) function as the fiduciary, this Court must determine whether this Plaintiff can recover the type of damages she seeks in Count IV, regardless of who exists as the fiduciary. Herdrich submits that ERISA provides for extracontractual damages in § 502(a)(3). Plaintiff cites *Blue Cross and Blue Shield of Alabama v. Lewis*, 753 F.Supp. 345, 347 (N.D.Ala. 1990), for the proposition that § 502(a) of ERISA allows for extracontractual, even punitive damages. Herdrich concedes, however, that the Seventh Circuit does not follow the holding in *Lewis*, stating that "[i]t is doubtful that the Seventh Circuit's refusal to follow the ruling of the Alabama District Court is justified since the Seventh Circuit apparently ignored the intent of Congress." (Mem. in Opposition to Summary Judgment, at 4).

Defendants cite the Supreme Court's holding in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct 3085 (1985), for the proposition that ERISA

prohibits the award of extracontractual damages. ERISA's civil enforcement provision, § 502(a) provides, in relevant part,

A civil action may be brought—

- (1) by a participant or beneficiary—
 - (A) for the relief provided for in subsection (c) of this section, or
 - (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of his plan;
- (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
- (3) by a participant, beneficiary, or fiduciary
 - (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
 - (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a). Section § 409, entitled Liability for breach of fiduciary duty states, in part,

- (a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and

shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a).

In *Russell*, the plaintiff received benefits under an employee welfare benefit plan for a back injury from May 1979 until October 17, 1979 when an orthopedic surgeon reported that the plaintiff was no longer disabled. *Russell*, 473 U.S. at 136. The plaintiff requested a review of the termination of her benefits and proffered a report from her psychiatrist "... indicating that she suffered from a psychosomatic disability with physical manifestations rather than an orthopedic illness." *Id.* When this report was confirmed by a second psychiatrist, the plan administrator reinstated plaintiff's benefits -- including a retroactive payment. *Id.* The plaintiff's suit, brought under § 502(a)(2), alleged that she sustained an injury "by the improper refusal to pay benefits from October 17, 1979, when her benefits were terminated, to March 11, 1980, when her eligibility was restored." *Id.*

The Court granted certiorari "to review both the compensatory and punitive components of the Court of Appeals holding that § 409 authorizes recovery of extracontractual damages." *Id.* at 138. The Court held that § 502(a)(2) authorizes a plan beneficiary to bring suit against a fiduciary under § 409. Any recovery for a breach of fiduciary duty, however, "inures to the benefit of the plan as a whole." *Id.* at 140. Further, the Court's decision states that within the context of §§ 502(a)(2) and 409, "we do not find in § 409 express authority for an award of extracontractual damages to a beneficiary." *Id.* at 144. The Court did not address whether a plan could recover extracontractual damages from a fiduciary under § 409. *Id.* at n.12. The Court noted that because the

plaintiff relied "... entirely on § 409(a), and expressly disclaimed reliance on § 502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extra-contractual damages." *Id.* at 139, n.5. Therefore, regardless of the identity of the fiduciary, to the extent that Plaintiff seeks recovery of extracontractual damages under §§ 502(a)(2) and 409(a), summary judgment is granted in favor of the Defendants.

The plaintiff in *Russell* also argued that a private right of action for extracontractual damages should be implied absent an express authorization by ERISA. *Russell*, 473 U.S. at 145. The Court looked to the four-factor test employed by *Cort v. Ash*, 422 U.S. 66, 78 (1975), to determine whether an implied right of action for extracontractual damages exists under ERISA. *Id.* at 145. The Court declined to extend the *Ash* decision to "authorize the recovery of extracontractual damages. Because 'neither the statute nor the legislative history reveals a congressional intent to create a private right of action.'" *Id.* at 148 (quoting *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 94, n.31 (1981)). To the extent Herdrich argues for an implied right of action for extracontractual damages, the *Russell* case controls. No such right exists.

As the *Russell* decision left open the issue of whether § 502(a)(3) would permit recovery of extra-contractual damages, this Court must now turn to Plaintiff's argument that after the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990), § 502(a)(3) should be found to allow for the recovery of extracontractual damages by a plan beneficiary. In *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), cert. denied, 113 S.Ct. 61 (1992), the plaintiffs filed a suit against their employer, a law firm, and the employee welfare benefit plan to which they belonged. *Harsch*, 956 F.2d

at 652-53. The plaintiffs alleged that their employer "had refused to comply with the plaintiffs' written request for information and claims for benefits, in violation of the terms of the plan, the policy and practices of the firm, and ERISA" and sought compensatory and punitive damages. *Id.* at 653. In holding that neither § 502(a)(1)(B) nor § 502(a)(3)(B) provided for compensatory damages, the *Harsch* court discussed the impact of *McClendon* on the *Russell* holding. *Id.* at 655, 659-660. The Seventh Circuit focused on the last paragraph of the *McClendon* opinion which states:

[T]here is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek "pension benefits." It is clear that the relief requested here is well within the power of the federal courts to provide. Consequently, it is no answer to a preemption argument that a particular plaintiff is not seeking the recovery of pension benefits.

Id. at 659 (quoting *McClendon*, 111 S.Ct. at 486). After summarizing the post-*McClendon* case law, including *Blue Cross and Blue Shield v. Lewis*, *supra*, the case our Plaintiff relies upon, and *International Union, United Automobile, Aerospace and Agricultural Implement Workers v. Midland Steel Products, Co.*, 771 F.Supp. 860, 863 (N.D. Ohio 1991), the Seventh Circuit concluded that the dicta from *McClendon* did not authorize the recovery of compensatory damages under § 502(a)(3). *Id.* at 660 ("we are not rash enough to believe that the Court intended to overrule settled law in most of the circuits, as well as narrowly limit—if not overrule—its own decision in *Russell* in such an off-hand manner").

As to the availability of punitive damages under either § 502(a)(1)(B) or § 502(a)(3), the *Harsch* court found neither

section of ERISA allowed for punitive damages. *Id.* at 661. Specifically as to § 502(a)(3), the court cited its prior holding in *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987) (punitive damages are not available under § 502(a)(3)). Other courts have relied upon *Harsch* in finding that § 502(a)(3) does not provide for extracontractual damages. See, e.g., *Lafoy v. HMO Colorado*, 988 F.2d 97, 99 (10th Cir. 1993); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 32 (5th Cir. 1993); *Zimmerman v. Sloss Equipment, Inc.*, 835 F.Supp. 1283, 1291 (D.Kan. 1993); *Pension Plan of Public Service Assoc. of New Hampshire et al. v. KPMG Peat Marwick*, 815 F.Supp. 52, 56-57, n.2 (D.N.H. 1993). Although Herdrich suggests that the Seventh Circuit's decision in *Harsch* is an incorrect reading of *Russell* and *McClendon*, this Court chooses to follow the Seventh Circuit's well reasoned holding.

Additionally, the Supreme Court has recently elaborated on the reference in § 502(a)(3)(B) to "other appropriate equitable relief." *Mertens v. Hewitt Assoc.*, 113 S.Ct. 2063 (1993). The Court granted certiorari to answer the question "... whether ERISA authorizes suits for money damages against non-fiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty." *Id.* at 2066. In determining that a beneficiary may not recover monetary damages from a non-fiduciary, the Court held that § 502(a)(3)(B) included typical remedies available in equity and not "legal remedies" like compensatory damages or monetary relief. *Id.* at 2069. The *Mertens* decision was limited to the type of damages which may be recovered under § 502(a)(3). *Amweiler v. American Elec. Power Service Corp.*, 3 F.3d 986, 993 (7th Cir. 1993). Thus, *Mertens* gives further support to this Court's conclusion that to the extent Herdrich relies on § 502(a)(3)(B) as a basis for monetary relief, as opposed to equitable relief, she may not proceed as a matter of law. This Court finds that Plaintiff's claim for extracontractual damages

against Defendant Health Alliance may not, as a matter of law, survive summary judgment. As this Court's finding is not specific to Health Alliance, but may be applied to any fiduciary, Plaintiff's Motion for Leave to Amend is denied as to Count IV.

B. Count III

As the Magistrate Judge left open the question of whether Count III of Plaintiff's Complaint is preempted, this Court must determine, as a jurisdictional matter, whether Count III is preempted by ERISA. If not, the matter should be remanded to State court. As set forth above, Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq.* Specifically, Plaintiff claims that Carle Clinic sold her a subscription in Carle HMO through its wholly owned subsidiary Health Alliance. Plaintiff maintains that Defendant Carle Clinic violated the Consumer Fraud act by failing to advise her that the Carle HMO physicians hired by Health Alliance, in fact owned Health Alliance. Plaintiff also avers that Defendant Carle Clinic failed to inform her that the compensation of Carle HMO physicians was "increased to the extent that those physicians did not order diagnostic tests; did not utilize facilities not owned by those physicians; and did not make emergency or consultation referrals." (Addendum to Complaint, at 2). Count III seeks an amount in excess of \$15,000.00 plus costs and attorney fees.

In ERISA's § 1, Congress articulated its declaration of policy, stating: "... to provide for the general welfare and free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans." 29 U.S.C. § 1001(a). In ERISA, Congress set out to

"protect . . . participants in employee benefit plans . . . by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts."

29 U.S.C. § 1001(b). Herdrich's claim in Count III is essentially that Defendants failed to disclose relevant, material information regarding the operation of the Plan. In order to find Count III preempted by ERISA, the State law which forms the basis of the claim must "relate to" an employee welfare benefit plan. 29 U.S.C. § 1144(a). The Supreme Court has given a broad interpretation to the "relate[s] to" requirement. In *Shaw v. Delta Air Lines*, 463 U.S. 85, 97, 103 S.Ct. 2890, 2900 (1983), the Court held that "a law 'relates to' an employee benefit plan in the normal sense of the phrase, if it has a connection with or reference to such plan." *Shaw*, 463 U.S. at 97.

ERISA contains detailed disclosure requirements. In § 101, the statute requires the administrator of each employee benefit plan to provide all participants with a summary plan description and fiscal statements and schedules. 29 U.S.C. § 1021(a). The summary plan description must include the following:

The name and type of administration of the plan;
the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are

persons different from the administrator); a description of the relevant provisions of an applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part.

29 U.S.C. § 1022(b). Additionally, ERISA requires each employee benefit plan publish an annual report, which is to be filed with the Secretary and made available to the plan participants and beneficiaries. 29 U.S.C. §§ 1023(a)(1)(A) and 1024(a) & (b). The annual report must contain a financial statement and opinion. 29 U.S.C. § 1023 (a)(1)(B)(i). The financial opinion must issue from an independent qualified public accountant. 29 U.S.C. § 1023(a)(3)(A). The financial statement must include "a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position." 29 U.S.C. § 1023(b)(1). The notes accompanying the financial statement must contain the following disclosures:

[A] description of the plan including any significant changes in the plan made during the

period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with person known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of the plan.

29 U.S.C. § 1023(b)(1). ERISA also dictates the schedules which must be attached to the financial statements. 29 U.S.C. § 1023(b)(3). The annual report must also contain an actuarial statement and opinion prepared by an enrolled actuary. 29 U.S.C. § 1023(a)(4)(A).

It is apparent from this brief review of ERISA's disclosure requirements that the statute comprehensively regulates the necessary disclosures. Count III seeks to impose additional disclosure requirements on the plan administrator other than those which are expressly enumerated in ERISA. This Court finds that under the broad reach of ERISA's § 514, Plaintiff's Count III relates to an employee benefit plan, and as such is preempted.

Having found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be provide a cause of action for Plaintiff. The availability of a federal remedy does not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA. *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989). Plaintiff is given leave to submit an amended Count III which

clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision. If Plaintiff declines this opportunity, Count III will be dismissed with prejudice, and the remaining matters will be remanded to State Court.

Conclusion

For the reasons stated herein, the Motion for Summary Judgment as to Count IV is GRANTED in favor of Defendant Health Alliance Medical Plans, Inc. with costs. The Motion for Summary Judgment as to Count III is DENIED. The Plaintiff has fourteen (14) days to file her amended Complaint as to Count III, specifying under which of ERISA's civil enforcement provisions she intends to proceed. IT IS SO ORDERED.

ENTERED this 25th day of July, 1995.

/s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

APPENDIX F

UNITED STATES DISTRICT COURT CENTRAL DISTRICT OF ILLINOIS

AMENDED JUDGMENT IN A CIVIL CASE

CYNTHIA HERDRICH,

vs.

Case Number 94-1143

LORI PEGRAM, M.D., CARLE
CLINIC ASSOCIATION, HEALTH
ALLIANCE MEDICAL PLANS, INC.,
and CARLE HEALTH INSURANCE
MANAGEMENT CO., INC.

☒ JURY VERDICT. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

IT IS ORDERED AND ADJUDGED that defendants Health Alliance Medical Plans, Inc and Carle Health Insurance Company, Inc are dismissed on 4/15/96. Judgment is entered in favor of Plaintiff and against Defendants Lori Pegram and Carle Clinic Association as employer of defendant Lori Pegram in the amount of \$50,000 total damages with 30% negligence attributable to Plaintiff Cynthia Herdrich with recoverable damages in the sum of \$35,000.00, plus costs of

suit. Further that on 2/10/97, costs are taxed in favor of Plaintiff and against Defendants in the sum of \$232.00.

ENTER this 10th day of February, 1997.

/s/ John Waters
JOHN M. WATERS, CLERK

/s/ H. Williams
BY: DEPUTY CLERK

APPENDIX G

**IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION**

CYNTHIA HERDRICH,)	
)	
Plaintiff,)	
)	
vs.)	No. 94-1143
)	
LORI PEGRAM and CARLE)	
CLINIC ASSOCIATION, HEALTH)	
ALLIANCE MEDICAL PLANS, INC.,)	
CARLE HEALTH INSURANCE)	
MANAGEMENT CO., INC.,)	
)	
Defendants.)	

AMENDED COUNT III

NOW COMES plaintiff, CYNTHIA HERDRICH, by her attorneys, Hayes, Hammer, Miles, Cox and Ginzkey complaining of CARLE CLINIC ASSOCIATION, P.C. (hereinafter "CARLE"), HEALTH ALLIANCE MEDICAL PLANS, INC. (hereinafter "HAMP") and CARLE HEALTH INSURANCE MANAGEMENT CO., INC. (hereinafter "CHIMCO") as follows:

THE PARTIES

1. CARLE is an Illinois corporation comprised of owner/physicians and is doing business in the central district of Illinois.
2. HAMP is a for-profit Illinois Domestic Stock Insurance Company doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.
3. CHIMCO is a for-profit Illinois corporation doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.

JURISDICTION

4. This court has jurisdiction pursuant to 29 USC 1101, 1109 and 1132(a).

THE FACTS

5. In March of 1991 and thereafter, plaintiff's husband was employed by State Farm Mutual Automobile Insurance Company (hereinafter "State Farm").
6. Prior to March of 1991 and annually thereafter, for valuable consideration, through State Farm, defendants sold plaintiff a subscription in CARLE CARE HMO, a pre-paid health insurance plan (hereinafter "the Plan") arranging medical and hospital services for subscribers (see attached Exhibit A).

7. State Farm retained no right to direct or control the administration of the Plan.
8. Defendants have the exclusive right to decide all disputed and non-routine claims under the Plan.
9. Under the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan.
10. Defendant is a participant and beneficiary under the Plan and brings this action on behalf of the Plan pursuant to 29 USC 1132(a).
11. Defendants are fiduciaries with respect to the Plan and under 29 USC 1109(a) are obligated to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries and
 - a. for the exclusive purpose of:
 - i. providing benefits to participants and their beneficiaries; and
 - ii. defraying reasonable expenses of administering the Plan;
 - b. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.
12. In breach of that duty:

- a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;
- b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:
 - i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:
 - (1) minimize the use of diagnostic tests;
 - (2) minimize the use of facilities not owned by CARLE; and
 - (3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians.
 - ii. by administering disputed and non-routine health insurance claims and determining:
 - (1) which claims are covered under the Plan and to what extent;
 - (2) what the applicable standard of care is;
 - (3) whether a course of treatment is experimental;
 - (4) whether a course of treatment is reasonable and customary; and
 - (5) whether a medical condition is an emergency.

- 13. As a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses made by HAMP and CHIMCO to CARLE, as well as those amounts which would have been realized by prudently investing those supplemental medical expenses.

WHEREFORE, plaintiff prays an order of this court:

- a. Requiring CARLE to reimburse the supplemental medical expense payments received from HAMP and CHIMCO, and a reasonable rate of return thereon;
- b. For an award of court costs and attorney fees; and
- c. For such other equitable relief as this court deems just.

CYNTHIA HERDRICH, plaintiff

BY: /s/ James P. Ginzkey
One of her attorneys

James P. Ginzkey
HAYES, HAMMER, MILES, COX & GINZKEY
202 North Center Street
Bloomington, Illinois 61701
309/828-7331

STATE OF ILLINOIS)
) ss.
COUNTY OF McLEAN)

PROOF OF SERVICE

The undersigned certifies that the foregoing instrument was served upon all parties to the above cause by (U.S. Mail) (Federal Express) (hand-delivering) a copy thereof to:

Peter W. Brandt
Livingston Law Firm
115 West Jefferson Street
Bloomington, Illinois 61701

the attorney of record herein at his respective address as disclosed on the pleadings, on August 4, 1995 .

/s/ Donna M. Hansen

Subscribed and sworn to before me this
4th day of August ,
1995 .

/s/ Tami J. Grizzle
Notary Public

CarleCare
Health Maintenance Organization
602 West University Avenue
Urbana, IL 61801 (217) 337-8000

EXHIBIT A

HERDRICH, RICK L.
207 S EVERGREEN LN
BLOOMINGTON, IL 61704

**Member Subscription
Certificate**

This Subscription Certificate, supplemented by the Face Sheet, Amendments and/or Riders attached hereto, in combination with the Employer Enrollment Agreement (if applicable) and the Application (if attached) constitute the entire agreement between the Subscriber named herein and CarleCare, Inc.

CarleCare is certified under the State of Illinois HMO Act of 1974 and holds a Certificate of Authority to do business as a prepaid health maintenance organization in the states of Illinois and Indiana.

This document specifies the benefits which the Subscriber and Eligible Dependents are entitled to receive as Members of CarleCare in consideration of the specified premiums paid by or on their behalf.

IN WITNESS WHEREOF, CarleCare, Inc.
has duly executed this certificate.

/s/ Harlan J. Fairlor, MD
Harlan J. Fairlor, MD
President

GROUP
SUBSCRIPTION CERTIFICATE FACESHEET

GROUP NUMBER 00229
GROUP NAME STATE FARM CORPORATE HEADQTRS

ID NUMBER 961040-00229

SUBSCRIBER EFF. DATE 1/01/90

HERDRICH RICK L
207 S EVERGREEN LN
BLOOMINGTON, IL 61704

SCHEDULE OF BENEFIT AND CO-PAYMENT LIMITS*

HOSPITAL INPATIENT - UNLIMITED DAYS PER
DISABILITY - \$100
CO-PAYMENT PER DAY - MAXIMUM \$100 CO-
PAYMENT PER HOSPITALIZATION.

INPATIENT MENTAL HEALTH - 30 DAYS PER
COVERAGE YEAR WITH A \$100 CO-PAYMENT PER
HOSPITALIZATION.

OUTPATIENT MENTAL HEALTH - UP TO 30 VISITS PER
COVERAGE YEAR WITH A \$15 CO-PAYMENT PER
VISIT.

INPATIENT SUBSTANCE ABUSE - UP TO 30 DAYS PER
COVERAGE YEAR WITH A \$100 CO-PAYMENT PER
HOSPITALIZATION.

OUTPATIENT SUBSTANCE ABUSE - UP TO 20 VISITS
PER COVERAGE YEAR WITH A \$0 CO-PAYMENT PER
VISIT.

DURABLE MEDICAL EQUIPMENT - PROVIDED WITH A
20% CO-PAYMENT.

PODIATRY WILL BE PROVIDED WITH A \$0 CO-
PAYMENT.

PROSTHETIC DEVICE - PROVIDED WITH A 20% CO-
PAYMENT.

DIAGNOSTIC EVALUATION/TREATMENT OF
INFERTILITY PROVIDED WITH 50% CO-PAYMENT.

OUTPATIENT PHYSICIAN VISITS - \$0 CO-PAYMENT
PER VISIT.

EMERGENCY ROOM VISITS \$20 CO-PAYMENT PER
VISIT.

ELECTIVE EPIDURAL ANESTHESIA FOR LABOR PAIN
MANAGEMENT IS COVERED WITH A 50% CO-
PAYMENT.

REFRACTORY EYE EXAMS FOR MEMBERS 17 YEARS
OF AGE AND UNDER ARE PROVIDED WITH A \$0 CO-
PAYMENT PER VISIT.

REFRACTORY EYE EXAMS FOR MEMBERS 18 YEARS
OF AGE AND OVER ARE PROVIDED WITH A \$0 CO-
PAYMENT PER VISIT.

MAXIMUM OUT-OF-POCKET EXPENSES FOR CO-PAYMENTS AS DESCRIBED HEREIN SHALL NOT EXCEED 100% OF THE AVERAGE ANNUAL PREMIUM PER MEMBER PER CONTRACT YEAR.

GROUP SUBSCRIPTION CERTIFICATE AMENDMENTS
STATE FARM CORPORATE HEADQTRS

*AMENDMENTS: SECTION 2.2 SUBSTITUTE "UNMARRIED CHILD" WITH "NEVER MARRIED CHILD". DELETE "UNDER THE AGE OF NINETEEN (19) . . . IS EARLIER;" SUBSTITUTE "UNDER THE AGE OF TWENTY-THREE (23)". SUBSTITUTE "AGE NINETEEN (19)" WITH "AGE TWENTY THREE (23)". SECTION 4.9 SUBSTITUTE "NINETEENTH (19) BIRTHDAY" WITH "TWENTY-THIRD (23) BIRTHDAY" AND "LAST DAY OF THE MONTH" WITH "LAST DAY OF THE YEAR" DELETE "ENROLLED . . . , OR".

GROUP SUBSCRIPTION CERTIFICATE

Introduction

CarleCare HMO, a product of Health Alliance Medical Plans, Inc., is organized as a health maintenance organization to do business as a prepaid health plan in Illinois and Indiana. In consideration of the payment of premiums by or on behalf of the Subscriber, CarleCare HMO agrees to arrange for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate, hereinafter "Certificate," including amendments, modifications and limitations set forth in the attached Face Sheet and any attachments herewith. Eligibility for benefits starts on the stated effective date and remains in effect for the remainder of the Group contract year unless earlier cancelled or terminated. This Certificate will be extended in its present form from contract year to contract year without further action unless notification to the contrary is given.

Section 1. DEFINITIONS

The following definitions apply to all provisions of this Certificate.

1.1 **CarleCare HMO** (hereinafter referred to as CarleCare) shall mean a health maintenance organization organized as a product of Health Alliance Medical Plans, Inc., and Illinois domestic stock insurance company.

1.2 **Group** shall mean the employer, association, union or other group as stated on the Face Sheet of this Certificate.

1.3 **Group Enrollment Agreement** shall mean the contract of which this certificate is a part between CarleCare and the Group whereby coverage is elected by the Group for those Subscribers and Family Dependent(s) enrolled hereunder.

1.4 **Subscriber** shall mean a person meeting the requirements of Section 2.1 who has enrolled in CarleCare and for whom the current premium payments have been received.

1.5 **Family Dependent(s)** shall mean a member of the family of a Subscriber as defined in Section 2.2.

1.6 **Member** shall mean either a Subscriber or a Family Dependent(s).

1.7 **Physician** shall mean a person licensed to practice medicine in all of its branches in the states of Illinois and Indiana.

1.8 **CarleCare Physician** means a Physician who is a member of, employed by or formally associated with a medical group having a contract to provide services to CarleCare Members.

1.9 **Primary Care Physician** means a CarleCare Physician selected by or on behalf of a Member to provide, arrange and coordinate a Member's care.

1.10 **General Service Area** shall mean Champaign, Clark, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Effingham, Ford, Iroquois, Jasper, Kankakee, Livingston, Macon, McLean, Moultrie, Piatt, Shelby and Vermilion counties in Illinois and Benton, Fountain, Newton, Montgomery, Parke, Vermillion, Vigo and Warren counties in Indiana.

1.11 **Family Coverage** shall mean the coverage provided for a Subscriber and his/her Family Dependent(s) by or on whose behalf the applicable family premium has been paid.

1.12 **Open Enrollment Period** means a period of time determined by CarleCare and the Group during which eligible Group members who have not previously enrolled in CarleCare may do so without evidence of insurability or of good health.

1.13 **Co-Payment** means a money payment required to be paid by or on behalf of a Member for certain services at the time and place such services are received. The schedule of Co-Payments is set forth in the Face Sheet of this Certificate. Total Co-Payments paid by or on behalf of a Member during a contract year shall not exceed 100% of the total annual premium for individual or Family Coverage, whichever is applicable, for one coverage year of the health care services provided under this Certificate or shall never exceed fifty (50) percent of a particular covered service. Provided application is made to CarleCare by the Subscriber within forty-five (45) days of the end of the coverage year to which such limitation applies, any excess in the amount of Co-Payments shall be refunded to the Subscriber.

1.14 **Medically Necessary** means the services, care or supplies which are required to identify or treat a Member's condition and is: (1) consistent with the symptom or diagnosis and treatment or distinct improvement of a Member's condition; (2) in accordance with standards of good medical practice; (3) not mainly for convenience of the Member, a Physician or other provider; and (4) the most appropriate medical service, supply or level of care which can safely be provided.

When applied to inpatient care, it further means that the Member's medical symptoms or condition require that the services cannot be safely provided to the Member as an outpatient.

1.15 **Substance Abuse** shall mean the uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency which develops with continued use and for which the Primary Care Physician determines that medical care is required. The addictive substances included under Substance abuse are limited to alcohol, morphine, cocaine, opium, and other barbiturates and amphetamines.

Section 2. ELIGIBILITY AND ENROLLMENT

Individuals eligible for enrollment must meet the following requirements.

2.1 **Subscriber:** To be eligible as a CarleCare Subscriber, an individual must be either an actual and bona fide member of the enrolled Group or be entitled by agreement, contract or other established standard to participate in insurance benefits arranged by the Group and so certified by the Group.

2.2 **Family Dependent(s):** To be eligible to enroll in CarleCare as a Family Dependent(s), an individual must be either:

- the spouse of a Subscriber, or
- a dependent, unmarried child under the age of nineteen (19) unless enrolled as a full-time student in which case

coverage may continue through the last day of the month of graduation or cessation of studies or age twenty-three (23), whichever is earlier; this refers to natural and adopted children of the Subscriber, stepchildren who reside on a full-time basis with the Subscriber, as well as to children for whom the Subscriber is the legal guardian and who is eligible to be claimed as a dependent for federal income tax purposes by the Subscriber.

A dependent who attains the age of nineteen (19) and is both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the Subscriber for support and maintenance will continue to be included under Family Coverage for the duration of the disability and dependency. The Subscriber shall submit documentary proof of disability and dependency when requested by CarleCare at specified intervals. These intervals are defined as every six (6) months for the first two (2) years after the date of the first request for service on behalf of the disabled and dependent person or from the date on which CarleCare is notified of the dependent's disability and dependency, whichever is earlier and annually thereafter.

2.3 A newly married Subscriber arranges for addition of spouse to Family Coverage by submitting request to CarleCare within 31 days of the marriage.

2.4 A newborn child of a Subscriber is automatically covered for 31 days after birth subject to the applicable premiums for such coverage. Coverage for a newborn shall include illness, injury, congenital defects, birth abnormalities and premature birth. To continue coverage of a newborn, a request for addition to a family membership (or a conversion from individual to family membership) must be submitted to

CarleCare within 31 days of birth. Premium for continued coverage of a newborn shall be payable from the date of birth.

2.5 During an Open Enrollment Period, subscribers and family dependents meeting the requirement of Section 2.1 and 2.2 may enroll in CarleCare by submitting completed applications on forms provided by CarleCare. No person is eligible to re-enroll hereunder who has had coverage terminated under Sections 4.5, 4.6, 4.7, or 4.8.

Section 3. PAYMENT FOR SERVICES FOR ENROLLED GROUP

3.1 Payment for services covered by this Certificate shall be made as follows: the Subscriber or anyone paying on his or her behalf shall remit to CarleCare monthly, the specified premium rate. Only a Member for whom the premium is actually received by CarleCare shall be entitled to the benefits of this Certificate and only for the month for which such payment is received.

3.2 The monthly premium rate shall be effective for a twelve month period of time and shall be subject to revision thereafter on a yearly basis as of the group's anniversary date. Notice of such revision in premium rate shall be provided to the Group not less than 60 days prior to the effective date of such revision.

3.3 The first monthly premium must be paid on or before the effective date of this Certificate and the succeeding premiums must be paid on or before the first day of each succeeding month in order for the benefits to be payable subject to the grace period provisions specified in Section 3.4.

3.4 If the Subscriber or anyone paying on his or her behalf fails to pay the premium within 31 days after it becomes due, this Certificate is automatically cancelled and covered members are not entitled to further benefits. If a Subscriber terminates employment with the Group, coverage under this Certificate shall terminate after the last day of the period for which the premium has been paid. A Subscriber who becomes ineligible for continued membership in the Group while the coverage agreement between CarleCare and the Group is in effect may be eligible for conversion to a direct payment plan as provided in Section 9.5.

Section 4. TERM AND TERMINATION OF AGREEMENT

4.1 The effective date of this Certificate is stated on the Face Sheet. The duration of this Certificate is for one year from the group's anniversary date, and it automatically will be renewed from Group year to Group year unless earlier cancelled or terminated.

4.2 Termination of this Certificate by either Group or by CarleCare may be accomplished at any time by termination of the Group Enrollment Agreement or by giving written notice of termination to the other party at least 60 days prior to the effective date of termination. The Group shall be responsible for notifying Members of termination of the Certificate under this Section 4.2.

4.3 Termination by CarleCare. In the event that CarleCare terminates this Certificate pursuant to Section 4.2, any member who is hospitalized at the effective date of termination shall receive the following benefits: all services otherwise available hereunder to patients, for the condition

under treatment, during the remainder of that particular episode of hospitalization, until determination by a Physician that hospitalization is no longer medically indicated. In maternity cases under care at the effective date of termination, CarleCare may at its election either (a) continue obstetrical care only through confinement and discharge, or (b) convert the Member from the Group to individual enrollment. Except as expressly provided in this subsection, all rights to benefits and services shall cease as of the effective date of termination.

4.4 Termination by the Group. In the event that the Group terminates this Certificate pursuant to Section 4.2, then all rights to benefits and services shall cease as of the effective date of termination.

4.5 CarleCare may terminate the rights of a Subscriber and covered Family Dependent(s) of the Subscriber for the following reasons only after affording the Subscriber a hearing before the Patient Satisfaction Committee of CarleCare and upon that Committee's recommendation: (a) willful provision of a CarleCare membership identification card to any person ineligible for CarleCare services; (b) failure to make payment to CarleCare within thirty (30) days of charges for non-covered services or of Co-Payments required for covered services; (c) permanent residency changes to an area not included in Section 1.9.

4.6 CarleCare may terminate the rights of a Subscriber and covered Family Dependent(s) of the Subscriber by reason of the unreasonable refusal of the said Subscriber or Family Dependent(s) of the Subscriber to follow a prescribed course of treatment. Coverage may be terminated under this subsection only upon thirty (30) days prior written notice.

4.7 CarleCare may terminate the rights of the Subscriber and covered Family Dependent(s) of the Subscriber as of the effective date of enrollment by reason of fraud or material misrepresentation in enrollment, or as of the date of discovery of fraud or misrepresentation in the use of services or facilities provided under this Certificate.

4.8 CarleCare may terminate the rights of the Subscriber and covered Family Dependent(s) of the Subscriber by reason of any material violation of the terms of this Certificate by the Subscriber or any Family Dependent(s) of the Subscriber.

4.9 The dependent coverage of a child terminates on the last day of the month of his/her nineteenth (19) birthday unless the child is enrolled as a full-time student, in which case coverage may continue through the last day of the month of graduation or cessation of studies or age twenty-three (23), whichever is earlier, or (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the Subscriber for support and maintenance in which case such child will continue to be included under Family Coverage for the duration of the disability and dependency.

Section 5. PHYSICIAN-PATIENT RELATIONSHIP

5.1 The Primary Care Physicians shall maintain traditional physician-patient relationships with Members. Every Member will be asked to select a Primary Care Physician at the time of enrollment. Changing Primary Care Physicians is permissible at any time by writing CarleCare.

5.2 Information from medical records and information received by Physicians incidental to the physician-patient relationship shall be kept confidential. It shall not be disclosed without the written consent of the Member, or if the Member is a minor, without the written consent of Member's parent or legal guardian.

Section 6. SERVICE SCHEDULE

The following Service Schedule specifies the services which the Subscriber and his/her enrolled Family Dependent(s) are entitled to receive as Members of CarleCare. All services are provided subject to the Limitations and Exclusions (see Sections 7 and 8) and in accordance with accepted medical and surgical practices and standards approved by the Medical Policy Committee of CarleCare and in conjunction with the Primary Care Physician.

6.1 CarleCare Physician Services - Outpatient

Diagnostic and treatment services are covered according to the provisions of Section 1.13. This coverage is subject to the exclusions in Section 8 and any Co-Payment per visit indicated on the Face Sheet of this Certificate. Preventive medical services, including the recommended periodic health care examinations and well baby care are covered when provided by the Primary Care Physician.

6.2 Physician Services - In Hospital

All covered services provided by CarleCare Physicians, including surgical procedures, anesthesia and consultant services, are provided when a Member is hospitalized subject to any Co-Payment indicated on the Face Sheet of this Certificate.

6.3 Hospital Care

Hospital services are provided for an unlimited number of days when hospitalization is ordered by the Primary Care Physician subject to any Co-Payment as set forth on the Face Sheet of this Certificate. (See Section 6.8 for information on inpatient mental health care and Section 6.10 on alcoholism, drug addiction/abuse). Except as noted in the exclusions, all hospital services are provided, including private duty nurses, when a CarleCare Physician determines that this type of care is Medically Necessary.

Members shall be hospitalized in semi-private (two-bed) accommodations unless it is Medically Necessary (as authorized by a CarleCare Physician) to occupy a private room (one-bed).

6.4 Skilled Nursing Facility

Inpatient services in an approved Skilled Nursing Facility are covered in full for a maximum of 120 days per Member per contract year when prescribed by the Primary Care Physician and authorized in advance by the Health Services Department. Custodial or convalescent care are not covered (see Section 8.7).

6.5 X-ray and Laboratory

All X-ray and laboratory tests and services approved by the CarleCare Medical Policy Committee are covered when Medically Necessary, requested by the CarleCare Physician and obtained at an approved CarleCare facility.

6.6 Maternity Care

Physician and hospital maternity care is provided when requested by a CarleCare Physician subject to any Co-Payment indicated on the Face Sheet of this Certificate.

6.7 Family Planning Services

Family Planning Services and consultation by CarleCare providers are a covered benefit. Covered diagnostic evaluation and treatment of infertility is subject to the Co-Payment specified for infertility on the Face Sheet of this Certificate (See Section 8.14 for information on exclusions.) This Co-Payment is applicable to outpatient care, inpatient care and infertility drugs. Outpatient infertility drugs are excluded for those members who do not have the prescription drug benefit.

Elective sterilization procedures (i.e. tubal ligations and vasectomies) are covered. Elective abortions and surgical procedures performed for reversal of voluntary sterilizations are not covered (see Sections 8.12 and 8.13).

6.8 Mental Health Care - Inpatient

Inpatient mental health services are provided as may be necessary and appropriate for short-term evaluation and/or crisis intervention. Up to twenty (20) days inpatient services, or the number set forth on the Face Sheet of this Certificate, shall be provided per member per contract year, subject to the co-payment set forth on the Face Sheet of this Certificate when authorized by the Primary Care Physician.

6.9 Mental Health Care - Outpatient

Outpatient mental health services shall be provided for short-term evaluation and/or crisis intervention. Up to twenty (20) outpatient visits, or the number set forth on the Face Sheet of this Certificate, per member per contract year, subject to the co-payment per visit set forth on the Face Sheet of the Certificate will be provided, when authorized by the Primary Care Physician. There will be no co-payment for initial evaluation. These services may be provided by a Physician, by a registered clinical psychologist, or by ancillary mental health

professionals under supervision of a Physician or registered clinical psychologist.

6.10 Substance Abuse

Diagnosis and the medical non-psychiatric treatment of Substance Abuse, such as detoxification, is provided on an unlimited basis when authorized by the Primary Care Physician.

Unless otherwise stated on the Face Sheet of this Certificate, coverage for Substance Abuse rehabilitation on an inpatient basis is subject to the limitations specified for treatment of Mental Health - Inpatient in Section 6.8 of the Certificate. The number of days used for Substance Abuse rehabilitation will reduce the number of days available for inpatient Mental Health treatment. Inpatient rehabilitation coverage does not include programs consisting primarily of counseling by individuals other than a Physician or Registered Clinical Psychologist, court ordered evaluations, care in lieu of detention or correctional placement, or Family retreats.

Unless otherwise stated on the Face Sheet of this Certificate, coverage for Substance Abuse rehabilitation on an outpatient basis is subject to the limitations specified for treatment of Mental Health Care - Outpatient in Section 6.9 of this Certificate. The number of visits used for Substance Abuse rehabilitation will reduce the number of visits available for outpatient Mental Health treatment.

6.11 Oral Surgery

Although general dental services are not provided, oral surgical procedures which are Medically Necessary and coordinated through the Health Services Department will be provided when authorized by the Primary Care Physician in connection with the following limited

conditions: traumatic injury to sound natural teeth within thirty (30) days of injury; traumatic injury to the jaw bones or surrounding tissue; or correction of a non-dental pathological condition such as cysts and tumors.

6.12 Eye Examinations and Hearing Tests

Vision and hearing screenings provided by the Primary Care Physician are covered for all Members. Examinations for prescribing glasses or for determining the refractive state of the eyes are covered for children through age 17 when ordered by the Primary Care Physician subject to the copayment specified on the Face Sheet of this Certificate.

Unless otherwise indicated on the Face Sheet of this Certificate, examinations for prescribing glasses or for determining the refractive state of the eyes are not covered for Members eighteen (18) years of age or older (See exclusions Section 8.15).

**6.13 Physical Therapy and
Rehabilitation Medicine**

Rehabilitation therapy for conditions incurred due to illness, injury or surgery is a service performed by a licensed physical therapist, occupational therapist or speech therapist. Inpatient and outpatient treatment is limited to up to sixty (60) treatments per condition when, in the judgment of the Primary Care Physician, significant improvement can be expected in the Member's condition.

**6.14 Injections and Immunizations,
Dressings and Casts**

Injections, immunizations, dressings, splints and casts are covered when administered by a CarleCare physician or by a nurse or other health professional under the direction of a CarleCare Physician. Self-administered dressings and other

disposable supplies, such as chemstrips and lancets, are not covered.

6.15 Restorative Plastic Surgery

Coverage is limited to Medically Necessary services when authorized by a Primary Care Physician to correct a functional defect which resulted from an acquired and/or congenital disease or injury. Cosmetic surgery to correct congenital anomalies in newborns is covered.

6.16 Home Health Services

Intermittent skilled nursing and skilled therapeutic home services are provided in full when under the direction and approval of a CarleCare Physician. Coverage must be authorized by the Health Services Department.

6.17 Ambulance Service

Ambulance services are provided when authorized by the CarleCare Physician or for traumatic injury or medical condition as described in Section 6.18. Such authorization will be given only when such services are Medically Necessary.

6.18 Emergency Medical Care

All care authorized by a CarleCare physician for an emergency condition is covered. A medical emergency is defined as a traumatic injury or medical condition which occurs unexpectedly and which, if not immediately treated, might cause complications or jeopardize the Member's full recovery. Heart attacks, cerebral vascular accidents (strokes), poisonings, loss of consciousness and convulsions are considered to be "medical emergencies." Similar conditions may also be determined by the Primary Care Physician to be medical emergencies.

A. In the Service Area

Unless the life or health of the Member would be in immediate danger if treatment was delayed, CarleCare Members are required to contact their Physician or designated ancillary health professional and follow their instructions. Visits to an emergency room are subject to a Co-Payment by the Subscriber as shown on the Face Sheet of this Certificate.

B. Outside the Service Area

A CarleCare Member requiring emergency medical or hospital care while temporarily outside the Service Area is covered. Out-of-area benefits are limited to payment or reimbursement of usual, customary and reasonable charges for emergency care required before the member can, without medically harmful results, return to the Service Area. Elective care or care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area are not covered. Payment will be made for unexpected hospitalization due to complications of pregnancy. Routine delivery at term outside the Service Area, however, will not be covered unless the Member is outside of the Service Area due to circumstances beyond her control. Out-of-area emergency room visits are subject to a Co-Payment as shown on the Face Sheet of this Certificate.

A CarleCare Member receiving emergency services either within the Service Area or outside the Service Area from non-CarleCare Physicians or hospitals is required to notify CarleCare within 48 hours, or as soon as reasonably possible, after care begins.

6.19 Health Education

Upon referral from a CarleCare Physician, health education services, including instruction in personal health care, management of health problems and information about the best

use of CarleCare facilities and services are available. A current list of covered health education classes will be available at the offices of CarleCare upon request of any Member.

6.20 Medical Social Services

Medical social services include discharge counseling, referrals to community service agencies and other related services to assist the Member and family in coping with the medical condition.

6.21 Durable Medical Equipment

Corrective and orthopedic appliances (such as leg braces, jobst stockings, knee sleeves) and durable medical equipment for home use (such as non-motorized wheelchairs, surgical beds, oxygen equipment) will be provided subject to any Co-Payment specified on the Face Sheet of this Certificate when determined to be Medically Necessary due to an injury, illness, or medical condition of the Member occurring while the Member was enrolled in CarleCare.

Items and supplies provided under this section must be prescribed by the Primary Care Physician and authorized in advance by the Health Services Department. Equipment will be made available to Members from CarleCare authorized providers through rental or purchase agreements, at the option of CarleCare.

To accord with changes in medical technology, CarleCare will maintain a list of items which are not covered under this benefit or which are covered only with advance written approval by the Medical Director of CarleCare.

6.22 Prostheses and Implants

Prosthetic devices (such as artificial limbs) and penile implants are subject to any Co-Payment specified on the

Face Sheet of this Certificate. Coverage will be provided for such items when determined to be Medically Necessary due to an injury, illness, or medical condition of the Member occurring while the Member was enrolled in CarleCare. Items provided under this section must be prescribed by the Primary Care Physician and authorized in advance by the Health Services Department.

To accord with changes in medical technology, CarleCare will maintain a list of items which are not covered under this benefit or which are covered only with advance written approval by the Medical Director of CarleCare.

6.23 Sexual Assault or Abuse Victims

Hospital and medical services that are an emergency shall be provided to the full extent of coverage without Co-Payment, if any, as set forth on the Face Sheet of this Certificate, for sexual assault or abuse victims.

6.24 Human Organ Transplants

Upon prior order or written referral of the Primary Care Physician, benefits will be provided for a liver organ or tissue transplant to an unmarried dependent child under the limiting age specified in the Subscription Certificate if Family Coverage is in force and if the organ or tissue transplant is necessitated because the unmarried dependent child has biliary atresia. In addition, benefits will be provided for cornea and kidney organ or tissue transplants. No organ or tissue not specifically named as covered in this Subscription Certificate or any Rider attached hereto, shall be eligible for Human Organ Transplant benefits.

6.25 Podiatry Services

Podiatry Services, when medically necessary and provided by an affiliated podiatrist, are covered when authorized by the Primary Care Physician subject to any Co-Payment per visit as set forth on the Face Sheet of this Certificate.

Section 7. LIMITATIONS

7.1 Circumstances Beyond Control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of CarleCare results in the facilities, personnel or financial resources of CarleCare being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of this subpart, CarleCare is required only to make a good-faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. NOTE: Language taken from Section 110.102(b) of the Federal Register.

7.2 Non-CarleCare Physician Services

Diagnostic and treatment services by non-CarleCare Physicians are provided only when referred by the Primary Care Physician and require prior written authorization from the CarleCare Medical Director except as stated in Section 6.18, Emergency Medical Care.

7.3 Coordination of Benefits

- A. All benefits and services under this Certificate are subject to a Coordination of Benefits limitation. When a beneficiary holds two or more health plans, benefits provided under the other plan shall be coordinated with

those provided under this Subscription Certificate. This includes benefits available under automobile no-fault and medical payments coverage as well as homeowner's insurance.

B. Necessary definitions include the following:

1. Other Plan means any Group arrangement other than this Certificate which provides a Member with hospital, medical, surgical or dental benefits and which consists of employer-sponsored Group insurance coverage, association-sponsored Group prepayment coverage, coverage under labor-management trustee plans, employer organization plans or employee benefit organization plans, or coverage under governmental programs or coverage required or provided by statute, but not student accident policies or Group franchise plans.
2. Allowable Benefits means the sum of each necessary, reasonable and customary item of expense incurred by a beneficiary, at least a portion of which is covered by this Certificate or some other Plan covering the Member. When a service provided is not otherwise valued in terms of money, then the reasonable cash value shall be deemed to be the benefit.
3. One Year Period means the period of twelve (12) consecutive months commencing on the first day on which a Member incurs an item of allowable benefit. Benefits may be reduced as follows: If the total benefits to which a Member

would be entitled under this Certificate and all other Plans, in the absence of this provision, for allowable benefits in one year period, exceed the Member's allowable benefits during same period, then the benefits under this Certificate shall be reduced, when required by the following paragraphs, so that the total benefits under all Plans will not so exceed the allowable benefits for the period. Benefits payable under any other Plan include the benefits that would be payable had the claim been duly made. If any other Plan contains provisions establishing the same rules as are set forth regarding Coordination of Benefits, then the benefits under this Certificate and such other Plan shall be determined by applying the following rules:

C. For the purpose of this Section, the Rules establishing the order of benefits determination are:

1. A Plan with no provision for coordination with other benefits is considered to pay its benefits before a Plan which contains such a provision.
2. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
3. Dependent Child/Parent not separated or divorced. Except as stated in Section 4 below, when this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

- a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
- b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. **Dependent Child/Separated or Divorced.** If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- a) First the Plan of the parent with custody of the child;
- b) Then the Plan of the spouse of the parent with custody of the child; and
- c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for

health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule (5) is ignored.

6. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Member, or Subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Benefits under this Certificate will not be increased by virtue of this Coordination of Benefits limitation. It shall be the obligation of any Member claiming benefits under this Certificate to notify CarleCare of the existence of all other Group contracts, as well as the benefits payable under any other Group contract. In administering these provisions, CarleCare

shall have the right to release to any Physician, other medical professional, insurance company or any other person or organization, any claim information including copies of records relating thereto, to pay to any other organization any amount determined to be warranted under this Certificate, and to recover any over-payment which CarleCare may have made to any person or organization.

7.4 If Hospitalized on Effective Date

A Member who is hospitalized prior to the effective date of his/her enrollment in CarleCare is covered as of the date of eligibility. However, expenses incurred prior to the effective date of eligibility in CarleCare are not covered.

7.5 Worker's Compensation and Employer Liability Laws

Care will be provided to CarleCare Members for services covered under Worker's Compensation and employer liability laws. CarleCare will, however, seek reimbursement from the liable third party to the extent of medical liability, and it shall be the duty of the Member to complete such forms and provide such information as may be necessary and proper to assist CarleCare in obtaining reimbursement.

7.6 Reimbursement for Third Party Liability

If a member is injured or dies by reason of an act or omission of a third party, other than in relation to Worker's Compensation and employer liability laws covered under Paragraph 7.5 of this Certificate, services and supplies provided pursuant to this Certificate will be furnished to the Member for such injuries. By enrolling, a Member agrees that, if the Member is injured or dies by reason of an act or omission of a third party, CarleCare will have the following rights:

A. A lien in favor of CarleCare on any proceeds received, by way of judgment, settlement, or otherwise, by the Member to the extent of the reasonable cash value of the services and supplies furnished for such injuries. CarleCare may give notice of the lien to the third party whose act or omission caused the injuries to the Member, or his agent or insurance carrier, or where applicable, file the lien in the court having jurisdiction in the matter. A Member will not take any action to prejudice this lien right; and

B. To be reimbursed out of any proceeds received from the third party, to the extent of the reasonable cash value of the services and supplies furnished on behalf of the Member pursuant to this Certificate for such injuries, immediately upon receipt of the proceeds with respect to such Member, whether by judgment, settlement or otherwise. In the event a Member or his personal representative fails to institute a proceeding against such third party at any time prior to six (6) months before such action would be barred, CarleCare may, in its own name or in the name of the Member or his personal representative, commence a lawsuit against such third party for the recovery of damages by reason of such injury or death to the Member. From any damages recovered, CarleCare shall pay to the injured Member or his personal representative all sums received from such third party, whether by judgment, settlement or otherwise, in excess of the amount of the reasonable cash value of the services and supplies furnished pursuant to this Certificate, plus costs, and reasonable attorney's fees and expenses as may be incurred by CarleCare in prosecuting such action. The Member shall not take any action which would prejudice the rights of CarleCare hereunder and will

cooperate in doing what is reasonably necessary to preserve such rights of CarleCare. CarleCare shall not be obligated under the provisions of the fund doctrine for the payment of attorney fees and/or expenses from any proceeds, from whatever source, under which it is entitled to reimbursement hereunder.

Section 8. EXCLUSIONS

The following are NOT covered by CarleCare:

8.1 Care by Physicians Not Associated with CarleCare

Care by Physicians, other than CarleCare Physicians or Providers, or in hospitals not associated with CarleCare (except in a medical emergency or as stated in Section 7.2).

8.2 Governmental Responsibility

Care for military service connected disabilities for which the Member is legally entitled to services and for which facilities are reasonably available to the Member or for conditions that State or local laws require be treated in a public facility, unless legal liability exists (see Emergency Medical Care, Section 6.19). NOTE: Language taken from Section 110.102(d)(6) of the Federal Register.

8.3 Services Which Are Not Medically Necessary

Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage, or other services or supplies which are not, in the judgment of CarleCare Physicians, Medically

Necessary for the medical treatment or for the maintenance or improvement of the health of the Member.

8.4 Cosmetic Surgery

Conditions for which surgery is indicated primarily for cosmetic purposes (such as skin tags, lipomas). Restorative plastic surgery, however is covered as provided in Section 6.15.

8.5 Corrective Appliances or Devices, Except as Provided Under 6.22:

Including hearing aids, earmolds and durable medical equipment not considered Medically Necessary. This includes any dispensing fees incurred in obtaining the above-mentioned items.

8.6 Orthopedic Devices, Except as Provided Under 6.22:

Including heel cups, arch supports, gloves, lifts and wedges.

8.7 Custodial or Convalescent Care

Custodial or convalescent care for which facilities of an acute general hospital are not Medically Necessary in the judgment of a CarleCare Physician.

8.8 Dentistry

Dental care, dentures, restoration, orthodontic splints, correction of malocclusion, repair or extraction of teeth whether erupted or impacted, dental X-rays, anesthesia, analgesia or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures, except as expressly provided for in Section 6.11 of this Certificate.

8.9 Personal, Convenience, Disposable or Comfort Items or Services

Including grab bars, tub transfers, seat lifts, raised toilet seats, telephone and televisions. Disposable items such as lancets, monojectors and chemstrips are also not covered.

8.10 Experimental Treatment / Procedures / Transplants

Regardless of anything stated in this Certificate, CarleCare will not pay benefits for any charges incurred for any treatment, procedure or implant that is deemed to be experimental or investigational in nature by the technological assessment body established by the State of Illinois. Services or supplies related to sex transformation are also not covered.

8.11 Drugs

Except as provided by any rider attached hereto, any prescription drugs for outpatient care.

8.12 Reversal of Sterilization

Surgical procedures to reverse voluntary sterilization.

8.13 Elective Abortions

Abortions which are not Medically Necessary for the life or physical health of the mother are not covered or provided under this Certificate.

8.14 Infertility Services

Infertility Services excluded are artificial insemination which is not Medically Necessary, surrogate maternity care when surrogate is not a Member of CarleCare, invitro fertilization, embryo transplants, and other procedures deemed to be experimental or investigational in nature by the

technological assessment body established by the State of Illinois.

8.15 Refractory Treatment and Hearing Aid Evaluations

Eyeglasses, contact lenses, contact lens evaluations and fittings, and surgical correction for refractory errors and hearing aid evaluations are not provided.

8.16 Blood

Whole blood and its components, including derivatives. Cost relating to the administration and processing of blood and its components are covered.

8.17 Surgical treatment for obesity, such as stapling or by-pass.

8.18 Organ donor treatment or services where the Member serves as the organ donor.

Section 9. GENERAL PROVISIONS

9.1 CarleCare does not itself undertake to directly provide any health service benefits. CarleCare contracts with professional providers of care for the services received by Members under subscription certificates. CarleCare's obligation is limited to furnishing health services through contracts with such providers of care. CarleCare shall not be liable, in any event, for any act or omission of the professional personnel of any medical group, hospital or other provider of services to Members.

9.2 The health services benefits provided for in this Certificate are not transferrable to another party by any Member.

9.3 CarleCare is permitted to charge a reasonable fee to cover its costs for completing medical abstracts or insurance claim forms.

9.4 Medicare

A Member who attains the age of 65 or who is otherwise eligible for Medicare (i.e., a recipient of social security disability for a minimum of two years) may qualify for continued eligibility. After Medicare benefits become effective, a CarleCare Member can continue to receive care through the CarleCare facilities and arrangements; however, the Member must assign to the persons or organizations actually providing services or supplies the right to collect the applicable Medicare benefits.

9.5 Conversion

In the event that a CarleCare Member becomes ineligible for continued Group membership because of any reasons other than discontinuance of the Group's agreement with CarleCare where there is a succeeding carrier or failure of the employer to pay a required contribution, or because of termination described in Sections 4.5 and 4.6, the Member is eligible to convert to the direct payment plan then being offered by CarleCare for conversion purposes. Conversion must take place within 31 days following the termination of Group eligibility. Benefits and premium rates under the Group and direct payment plans may differ.

9.6 Indemnity in the form of cash will not be paid to any CarleCare Member except as follows:

As reimbursement for payments made to a Physician for which the Member had received prior authorization from CarleCare's Medical Director and for which CarleCare was liable at the time of the services.

As reimbursement for emergency services provided in accordance with Section 6.19.

9.7 The provisions of this Certificate cannot be altered or changed by any representative or agent of CarleCare, other than by a written amendment rider, amendment to the Face Sheet, or endorsement signed by President or Vice President of CarleCare.

9.8 Medically Necessary - Dispute Resolution

In the event of a dispute between the Primary Care Physician and CarleCare regarding the medical necessity of a covered service proposed by the Primary Care Physician, CarleCare will coordinate a timely review by a Physician holding the same class of license as the Primary Care Physician. This Physician will be unaffiliated with CarleCare and will be jointly selected by the Member (or the Member's next of kin or legal representative if the Member is unable to act for himself), the Primary Care Physician and CarleCare. If the reviewing Physician determines the covered service to be Medically Necessary, CarleCare will provide coverage for this service.

9.9 By the Group Enrollment Agreement, Group makes CarleCare coverage available to persons who are eligible under Section 2 of this Certificate. However, the Group Enrollment Agreement shall be subject to amendment, modification, or termination in accordance with any provision hereof or by mutual agreement between CarleCare and Group without the consent or concurrence of the Members. By electing medical or hospital coverage pursuant to this Group

Enrollment Agreement or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

9.10 Identification Card

Cards issued by CarleCare to Members pursuant to this Certificate are for identification only. Possession of a CarleCare identification card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under this Certificate have actually been paid. Any person receiving services or other benefits to which he is not entitled pursuant to the provisions of this Certificate shall be charged the Usual and Customary Fee therefore, in addition to any other remedies available to CarleCare as set forth herein. Identification cards are the property of CarleCare and shall be surrendered by Subscriber when CarleCare membership ceases.

9.11 Clerical Error

Clerical error, whether of the Group or CarleCare, in processing or maintaining any record pertaining to the coverage under this Certificate, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

9.12 Claims for Reimbursement

Any claims for reimbursement or bills of non-CarleCare providers for covered medical or hospital services rendered in an emergency must be submitted to CarleCare within sixty (60) days of the provision or initiation of the service, or as soon thereafter as reasonably possible. In no event will CarleCare be responsible for such claims or bills

submitted more than one year after the provisions or initiation of the service to which the claims or bill relates.

9.13 Grievance Procedure

Should the Member have a complaint about any medical or administrative matter connected with CarleCare services that is not resolved by the Primary Care Physician, clinic or hospital administrative personnel, the Member may call the CarleCare Member Relations Representative. If the Member feels the problem has not been resolved, the Member may submit a grievance in writing to the CarleCare Patient Satisfaction Committee. Written grievances must be received by the Patient Satisfaction Committee within 180 days from the date the event occurred giving rise to the Member's grievance.

The Patient Satisfaction Committee will meet promptly within thirty (30) days if possible but not longer than forty-five (45) days after receipt of any complaint addressed to the Committee. Each party to the complaint and/or his representative shall be heard by the Patient Satisfaction Committee. The Committee shall deliver and issue a final decision to the Member within ten (10) days of the hearing. The decision, if not contrary to law, contracts in force, or expressed Board policy, will be binding upon CarleCare.

If after review by the Patient Satisfaction Committee the problem is not resolved to the Member's satisfaction, Illinois residents may file a complaint with the Illinois Department of Insurance, Consumer Division or Public Services Section, Springfield, Illinois 62767. Indiana residents may file a complaint with the Department of Insurance, 509 State Office Building, Indianapolis, Indiana 46204.

9.14 Any notice to be given under the terms of this Certificate by CarleCare to the Group shall be in writing and

may be effected by deposit in any post office in the United States addressed to the Group at the most recent address of the Group shown in the records of CarleCare.

Any notice to be given under the terms of this Certificate by CarleCare to a Subscriber shall be in writing and may be effected by deposit in any post office in the United States addressed to the Subscriber at the address shown in the Face Sheet attached to this Certificate, unless notice of change of such address has been given by the Subscriber in the manner provided herein.

Any notice to be given under the terms of this Certificate to CarleCare shall be in writing and may be effected by deposit in any post office in the United States addressed to CarleCare at 602 W. University Avenue, Urbana, Illinois 61801.

All notices given in the manner provided for in this subsection shall be deemed to have been received by the party to whom addressed five (5) business days after deposit in said post office.

ADDITIONAL HUMAN ORGAN TRANSPLANT RIDER CARLECARE GROUP SUBSCRIPTION CERTIFICATE

- I. Upon prior or written referral of the Member's Primary Care Physician and subject to the terms, conditions, limitations and exclusions of the CarleCare, Inc., Subscription Certificate; the "Human Organ Transplants" Section(s) of the Subscription Certificate are amended by the addition of heart, heart/lung, bone marrow, pancreas, and liver transplants (Additional Transplants) from a donor to a transplant recipient Member when such services occur on or after the Effective Date of this Rider. Benefits under this Rider shall commence no earlier than five (5) days prior to the transplant Surgery and shall continue for a period of no longer than eighteen months after such Surgery. **No organ or tissue not specifically named as covered in the Subscription Certificate or this Rider, shall be eligible for Human Organ Transplants or Additional Transplants.**
- II. Whenever a heart, heart/lung, bone marrow, pancreas, or liver transplant (for other than an unmarried dependent child under the limiting age specified in the Subscription Certificate who has biliary artresia) is recommended by or on the referral of the Member's Primary Care Physician, the prospective transplant recipient must contact CarleCare, Inc., prior to the scheduling of the transplant Surgery. CarleCare, Inc., will then furnish the prospective transplant recipient Member or his Primary Care Physician with the names of the Providers which are authorized and approved by CarleCare, Inc., to perform the prescribed and covered transplant. No benefits will be provided for Additional Transplants and/or related services performed by any

Provider other than those which have been pre-approved by CarleCare, Inc.

III. In addition to the other exclusions and limitations of the Subscription Certificate and this Rider, benefits will not be provided for the following:

(A) Services unrelated to the heart, heart/lung, bone marrow, pancreas, or liver transplant except as specified in the Subscription Certificate or unrelated to the diagnosis or treatment of an illness resulting directly from such transplant.

(B) Drugs which are Experimental or Investigational.

IV. Unless earlier terminated by the Terms and Conditions of the CarleCare, Inc., Subscription Certificate, the benefits provided under this Rider shall end upon termination of the Rider by the Equitable Life Assurance Society of the United States.

Except as amended by this Rider, all Terms and Conditions of the CarleCare, Inc., Subscription Certificate to which this Rider is attached, shall remain in full force and effect.

JUL 28 1999

CLERK OF THE CLERK

No. 98-1949

IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION
and HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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PARTIES TO THE PROCEEDING

Carle Clinic Association, P.C. is an Illinois professional corporation comprised of licensed physicians, dentists and podiatrists. Health Alliance Medical Plans, Inc. is a for-profit Illinois domestic stock insurance company and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (App. 42a). Carle Health Insurance Management Company is a for-profit Illinois corporation and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (App. 42a).

These three entities file consolidated income tax returns. (App. 44a). Pursuant to Article III, Section 2 of Health Alliance's corporate by-laws, an appointment to the Board of Governors of Carle Clinic Association, P.C. results in an automatic appointment to the Board of Directors of Health Alliance. (App. 45a).

TABLE OF CONTENTS

	<i>Page</i>
Parties to the Proceeding	i
Table of Contents	ii
Table of Cited Authorities	iv
Table of Appendices	vii
Statement of the Case	1
A. The Petition Mischaracterizes the Ruling of the Court of Appeals	4
B. The Petition Mischaracterizes the Allegations of the Amended Complaint	7
Reasons for Denying the Writ	11
I. The Petition Overstates The Importance Of The Narrow Holding Below, Which Does Not Squarely Present The Question On Which Review Is Sought.	13
A. Petitioners Failed To Preserve Their Arguments In The Courts Below	13
B. Due to the Procedural Posture and Incomplete Record, This Case is Not An Appropriate Vehicle to Resolve This Highly Fact-Specific Issue	14

Contents

	<i>Page</i>
C. Court of Appeals' Decision Does Not Equate Medical Malpractice With Breach of Fiduciary Duty	17
II. Court Of Appeals' Decision Does Not Conflict With The Decisions Of This Court, Nor With The Decisions Of Other Courts. ..	18
A. Court of Appeals' Decision Complements, Rather Than Abrogates, Legislation Enabling Health Maintenance Organizations	18
B. Petitioners are Clearly Fiduciaries Under ERISA	19
Conclusion	21

TABLE OF CITED AUTHORITIES

	<i>Page</i>
Cases:	
<i>Biomet v. Black</i> , __ F. Supp. 2d __, (N.D. Ind. 1999)	20
<i>District of Columbia v. Greater Washington Bd. of Trade</i> , 506 U.S. 125, 113 S. Ct. 580, 121 L. Ed. 2d 513 (1992)	11, 12
<i>Health Cost Controls v. Bichanich</i> , 968 F. Supp. 396 (N.D. Ill. 1997)	20
<i>Hughes Aircraft Co. v. Jacobson</i> , __ U.S. __, 119 S. Ct. 755 (1999)	19, 20
<i>Ingersoll-Rand Co. v. McClendon</i> , 498 U.S. 133, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990)	12
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882, 116 S. Ct. 1783 (1996)	19, 20
<i>Moralis v. Health Plus, Inc.</i> , 954 F. Supp. 464 (D.P.R. 1997)	21
<i>O'Reilly v. Ceuleers</i> , 912 F.2d 1383 (11th Cir. 1990)	21
<i>Weiss v. CIGNA Healthcare, Inc.</i> , 972 F. Supp. 748 (D.C.N.Y. 1997)	6, 7

Cited Authorities

	<i>Page</i>
Statutes:	
28 U.S.C. § 1367	2
29 U.S.C. § 1002(1)	12
29 U.S.C. § 1002(21)(A)	12
29 U.S.C. § 1101	2
29 U.S.C. § 1104(a)	12
42 U.S.C. § 300(e)	13, 14, 18
815 ILCS 505/1 <i>et seq.</i>	2
Other Authorities:	
42 C.F.R. § 417.479	13, 14, 18, 19
61 Fed. Reg. 13432 (March 1996)	16
American Medical Association, <i>Principles of Medical Ethics</i> (1994)	6
Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977 (February 25, 1974), reprinted	12
2 Legislative History of the Employee Retirement Income Security Act of 1974, 3293	12

Cited Authorities

	<i>Page</i>
http://www.canceronline.org/009-the-ideal.html ..	16
http://www.humana.com/investor/1998annual/letter.html	17
http://www.kaiserpermanente.org/healthplans/doctorshands.html	16
http://www.kaiserpermanente.org/newsroom/structure.html	16
United States Department of Health & Human Services, <i>Incentive Arrangements Offered by Health Maintenance Organizations and Competitive Medical Plans to Physicians</i>	15
United States General Accounting Office, GAO/HRD-94-93, <i>Managed Healthcare Effect on Employers' Costs Difficult to Measure</i> (1993) ..	15

TABLE OF APPENDICES

	<i>Page</i>
Appendix A — Order Of The United States District Court For The Central District Of Illinois, Peoria Division Dated And Filed May 13, 1996	1a
Appendix B — Order Of The United States District Court For The Central District Of Illinois, Peoria Division Dated And Filed July 25, 1995	5a
Appendix C — Memorandum In Opposition To Plaintiff's Motion To Remand	23a
Appendix D — Annual Statement Of Health Alliance Medical Plans, Inc.	38a
Appendix E — Part 1 — Organizational Chart	42a
Appendix F — Notes To Financial Statements Of Health Alliance Medical Plans, Inc.	43a
Appendix G — Minutes Of April 6, 1992 Of The Annual Meeting Of Health Alliance Medical Plans, Inc.	45a

STATEMENT OF THE CASE

In March of 1991, petitioner Lori Pegram, respondent Cynthia Herdrich's doctor, discovered a 6 x 8 centimeter "mass" (later determined to be her appendix) in respondent's abdomen. 154 F.3d 362, 374. Although the mass was inflamed on March 7, Pegram delayed instituting immediate treatment of Herdrich, and forced her to wait more than one week (eight days) to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass. Ideally, Herdrich should have had the ultrasound administered with all speed after the inflamed mass was discovered in her abdomen in order that her condition could be diagnosed and treated before deteriorating as it did, but respondents' policy requires plan participants to receive medical care from Carle-staff facilities. *Id.* Respondent was forced to wait the eight days before undergoing the ultrasound at a Carle facility in Urbana, Illinois. During this unnecessary waiting period, Herdrich's health problems were exacerbated and her appendix ruptured, resulting in the onset of peritonitis. In an effort to defray the increased costs associated with the surgery required to drain and cleanse Herdrich's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that Herdrich travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois. *Id.*

Respondent Herdrich filed a two count complaint in State court on October 21, 1992. (App. 5a). Count I alleged medical negligence against petitioner Lori Pegram for failing to adequately examine, treat, and follow-up on respondent's complaint of right, lower quadrant pain. She claimed that Pegram's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a

ruptured appendix, which caused peritonitis. Count II sought to hold Carle Clinic Association liable under the theory of respondeat superior. Pegram and Carle Clinic filed an Answer to the State court complaint on December 8, 1992. (App. 6a).

Because it appeared that all the decisions as to respondent's treatment could be explained on the basis of petitioners' profit motive, respondent filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleged that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans in violation of the Illinois Consumer Fraud Act, 815 ILCS 505/1 *et seq.* Count IV charged Health Alliance breached its duty of good faith and fair dealing. (App. 6a).

The petitioners filed a Notice of Removal on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Respondent filed a Motion to Remand on April 8, 1994. (App. 6a).

In opposition to the Motion to Remand, petitioners argued that Counts III and IV related to the administration of a Plan and were thus preempted under ERISA. Specifically, petitioners set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. ***Petitioner's factual synopsis also asserted that Health Alliance was the administrator and fiduciary of the***

Plan. In their memorandum in opposition to respondent's motion to remand, petitioners stated:

The plaintiff, Cynthia Herdrich, was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her by her husband's employer, State Farm Insurance Companies. ***Defendant, Health Alliance Medical Plans, Inc. ("Health Alliance") was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. Section 1001 et seq.)***

(App. 24a).

* * *

In the case now before this Court, it is clear that the plaintiff's claims relate to the Plan administered by Health Alliance. The relationship between the plaintiff and Health Alliance arose solely from the Plan. ***But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and Health Alliance's serving as administrator/fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and Health Alliance and thus no lawsuit.***

(Emphasis added) (App. 36a).

This case was initially filed in state court. It was petitioners that sought and obtained removal to federal court. It was petitioners that sought and obtained a ruling that they were fiduciaries under ERISA. It was petitioners that sought

and obtained a ruling that ERISA governs this action. After seeking and obtaining these rulings, petitioners now argue that they are not fiduciaries, and that this action should not be governed by ERISA.

A. The Petition Mischaracterizes the Ruling of the Court of Appeals

Petitioners argue that the Court of Appeals “determined that the bare allegations that petitioners implemented cost-containment mechanisms that included potential rewards for physicians based on the Plan’s financial performance sufficed to state an ERISA claim for breach of fiduciary duty.” (Pet. 7, 9) Petitioners further assert that the “issue in this case is whether employer-sponsored health plans governed by ERISA may use the commonplace mechanisms for financing and delivering health care for their participants and beneficiaries,” (Pet. 14) and that, if the Court of Appeals’ decision is accepted, then “the principal organizational forms through which medical care is delivered today are unlawful.” (Pet. 15).

These arguments completely mischaracterize the ruling the Court of Appeals. The Court of Appeals explicitly stated that its decision does *not* stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty:

The dissent disagrees with this aspect of today’s holding, which it characterizes as concluding that “the mere existence of this asserted conflict [*i.e.*, the conflict between the incentive scheme for Carle doctors to limit medical care and treatment, on the one hand, and the fiduciary duty of Carle

to the beneficiaries, on the other], without more, gives rise to a cause of action for breach of fiduciary duty under ERISA.” *That is not the conclusion we reach. Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty.* Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses.)

154 F.3d 362 at 373 (emphasis added). The Court of Appeals went on to say:

The dissent also stresses that ERISA allows fiduciaries to adopt dual loyalties, and that maintaining dual loyalties does not in itself constitute a breach of fiduciary duty. We do not disagree with this contention, for it is well established that dual loyalties are tolerated under ERISA. *See, e.g., Donovan v. Bierwirth*, 538 F. Supp. 463, 468 (E.D.N.Y. 1981). Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of “loyalty” to his own financial interests. Tolerance, in other words, has its limits.

Id.

Petitioners also argue that the Court of Appeals stretched "the definition of a 'fiduciary' under ERISA," in order to hold that "health plans which include incentives to health care providers to contain costs are unlawful." (Pet. 9). Not only do these arguments mischaracterize the ruling of the Court of Appeals, they also completely ignore the fact that petitioners removed this case to federal court; that petitioners claimed to be fiduciaries under ERISA; and that petitioners argued that this case was governed by ERISA. Petitioners, at this point, are essentially arguing with themselves. Petitioners invoked federal jurisdiction and argued ERISA preemption in order to vitiate respondent's common law and statutory claims. After having been accommodated in their requests, petitioners are now arguing that they are not ERISA fiduciaries and that this action is not governed by ERISA!

Petitioners further argue that it is ironic that this ruling involves a physician-owned HMO because physicians cannot allow financial incentives to hinder patient care in light of the American Medical Association's *Principles of Medical Ethics* (1994). (Pet. 10). This argument firstly assumes that petitioners adhere to the AMA's principles of medical ethics, a fact upon which there has been no proof. But more importantly, the courts examining this issue have not found that the AMA's proscriptions afford patients adequate protection. In *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (D.C.N.Y. 1997) the court held that an HMO's "gag order" violated ERISA's fiduciary duties and stated:

It is true that a physician has an independent duty to provide full information to his or her patients, a duty which "is not altered by limitations in the coverage provided by the patient's managed care plan." (See Council on Ethical and Judicial

Affairs, American Medical Association Ethical Issues in Managed Care, Council Report, 273 JAMA 330 (Jan. 25, 1995)). A patient therefore cannot be deprived of such information absent an ethical breach on the part of the physician. Nonetheless, CIGNA's alleged rule mandating such an ethical breach upon pain of termination would provide many physicians with no meaningful choice and would effectively limit the amount of information available to Plan participants.

Weiss at 752.

B. The Petition Mischaracterizes the Allegations of the Amended Complaint

Petitioners argue that, in Count III of her complaint, Herdrich alleged that petitioners breached their fiduciary duty under ERISA by establishing a cost-containment mechanism which provided physicians with a "year-end distribution" based on the savings achieved by cost-containment, (Pet. 15) and that therefore, the Court of Appeals' essential holding is that ERISA health care plans "have a fiduciary duty not to adopt HMO(s) or other managed care options because cost-containment incentives create a conflict of interest for the health care provider." (Pet. 9). But the Court of Appeals did not hold, and respondent did not allege, that cost-containment incentives, standing alone, constitute a breach of ERISA fiduciary duties. Rather, respondent alleged, in great detail, that here the particular corporate structure between the medical clinic (Carle Clinic), the insurance company (Health Alliance), and the individual physician-owners, created a conflict of interest. Due to this

peculiar corporate structure, the primary care physicians and the insurance company offering the HMO are the alter egos of Carle Clinic. Carle Clinic and Health Alliance file consolidated income tax returns. (App. 44a) Appointment to the Carle Clinic Board of Governors results in an automatic appointment to the Health Alliance Board of Directors. (App. 45a) Health Alliance is a for-profit Illinois stock insurance company, 100% of which is owned by Carle Clinic. The physicians, as owners of 100% of the stock of Health Alliance, not only employ themselves, but also completely control the claims processing and utilization review functions of Health Alliance. Respondent did not allege the mere existence of cost containment incentives. Respondent alleged:

6. Prior to March of 1991 and annually thereafter, for valuable consideration, through State Farm, defendants sold plaintiff a subscription in CARLE CARE HMO, a pre-paid health insurance plan (hereinafter "the Plan") arranging medical and hospital services for subscribers (see attached Exhibit A).
7. State Farm retained no right to direct or control the administration of the Plan.
8. Defendants have the exclusive right to decide all disputed and non-routine claims under the Plan.
9. Under the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan.

10. Defendant [sic] is a participant and beneficiary under the Plan and brings this action on behalf of the Plan pursuant to 29 USC 1132(a).

11. Defendants are fiduciaries with respect to the Plan and under 29 USC 1109(a) are obligated to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries and

(a) for the exclusive purpose of:

- (i) providing benefits to participants and their beneficiaries; and
- (ii) defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.

12. In breach of that duty:

- (a) CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;

(b) Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

(i) by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians;

(1) minimize the use of diagnostic tests;

(2) minimize the use of facilities not owned by CARLE; and

(3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians.

(ii) by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency.

13. As a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses made by HAMP and CHIMCO to CARLE, as well as those amounts which would have been realized by prudently investing those supplemental medical expenses.

Petitioners implore this Court to ignore the fact that respondent's allegations were very fact-specific, and to ignore the fact that the ruling of the Court of Appeals was very fact specific.

REASONS FOR DENYING THE WRIT

ERISA is a statutory scheme which regulates all "private employee benefits plans, including both pension plans and welfare plans." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 127, 113 S. Ct. 580, 582, 121 L. Ed. 2d 513 (1992). The definition of a "welfare plan" includes "any plan, fund, or program" maintained for the purpose of providing medical or other health benefits for

employees or their beneficiaries "though the purchase of insurance or otherwise." *Id.* (quoting 29 U.S.C. § 1002(1)). ERISA establishes uniform standards, including rules relating to "reporting, disclosure, and fiduciary responsibility." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137, 111 S. Ct. 478, 482, 112 L. Ed. 2d 474 (1990).

In order to properly state a claim for breach of fiduciary duty under ERISA, a complaint must allege facts which set forth: (1) that the defendants are Plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted. *See* 29 U.S.C. § 1104(a).

ERISA defines the term "fiduciary" in 29 U.S.C. § 1002(21)(A), which reads, in relevant part:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority of control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Congress, when it enacted ERISA, intended that this statutory definition of "fiduciary" be broadly interpreted. As stated by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (February 25, 1974), *reprinted*, 2 Legislative History of the Employee Retirement Income Security Act of 1974 at 3293:

The Committee has adopted the view that the definition of fiduciary is of necessity broad . . . A fiduciary need not be a person with direct access to the assets of the plan. . . Conduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . .

I.

THE PETITION OVERSTATES THE IMPORTANCE OF THE NARROW HOLDING BELOW, WHICH DOES NOT SQUARELY PRESENT THE QUESTION ON WHICH REVIEW IS SOUGHT.

A. Petitioners Failed To Preserve Their Arguments In The Courts Below

In opposing Herdrich's appeal to the Seventh Circuit, Petitioners did not argue, as they now do in their petition for writ of certiorari, that there was no breach of fiduciary duty. Rather, petitioner's argued firstly that there was no appellate jurisdiction and secondly, that Herdrich had not established that petitioners were fiduciaries. Indeed, in opposing Herdrich's appeal to the Seventh Circuit, petitioners argued that there was no need to even discuss the issue of cost containment incentives, arguing that that question was "inappropriate at this stage of the litigation." At no point during the initial appeal did petitioners argue 42 U.S.C. § 300(e) (enabling legislation) or 42 C.F.R. § 417.479 (Medicare and Medicaid regulation). Quite to the contrary, petitioners argued that this was a case of first impression.

Petitioners did not make any arguments concerning 42 U.S.C. § 300(e) and 42 C.F.R. § 417.479 until they filed their motion for rehearing. Even in that motion for rehearing, petitioners emphasized that this was a case of first impression, that no federal appellate court had ever addressed the allegations made in Herdrich's complaint, and that the majority opinion "created what some might perceive as new precedent."

The arguments that petitioners now make were not properly presented below. In initially opposing Herdrich's appeal, petitioners made absolutely no arguments about any alleged conflicts with federal statutes or agency rulings concerning HMOs.

B. Due to the Procedural Posture and Incomplete Record, This Case is Not An Appropriate Vehicle to Resolve This Highly Fact-Specific Issue

Petitioners' motion for rehearing *en banc* was denied by the Court of Appeals with Justice Easterbrook filing a written dissent. Here the petition cites the dissent of Justice Easterbrook at great length. But Justice Easterbrook assumed quite a number of facts that were not in evidence. Petitioners quote Justice Easterbrook as stating that, if the Court of Appeals' decision stands, then "the principal organizational forms through which medical care is delivered today are unlawful," (Pet. 9) and that "[p]hysicians own much of the stock of HMOs organized as corporations." (Pet. 26).

Justice Easterbrook is wrong. Because respondent's fiduciary duty count was dismissed at the pleading stage, specific facts were not presented. For instance, Justice Easterbrook has no way of knowing whether the plan in question was self-insured (meaning that the risk of loss was

retained by the plan sponsor), or whether the plan was an insured plan (meaning that the risk of loss falls on the plan itself). Neither does Justice Easterbrook know whether the HMO in question here is a staff model, group model, IPA model, or direct contract model, and whether the distinction between those models was affected by the corporate structure chosen by petitioners. Likewise, no evidence was adduced concerning the issue of whether the HMO in question is federally qualified or not. Like Justice Easterbrook, here petitioners jumped to the conclusion that all HMOs are alike. Frankly, nothing could be further from the truth.

As reported by the United States General Accounting Office, GAO/HRD-94-93, *Managed Healthcare Effect on Employers' Costs Difficult to Measure* (1993):

The term "managed care" lacks a commonly accepted definition. It has been used to characterize a wide range of health care plans that select a network of physicians and hospitals, negotiate reimbursement levels, and apply controls on the use of services. The spectrum of such plans ranges from simple preferred provider networks to more tightly structured health maintenance organizations (HMOs).

In 1990, the United States Department of Health & Human Services presented a report to Congress entitled, *Incentive Arrangements Offered by Health Maintenance Organizations and Competitive Medical Plans to Physicians*, which concluded that the results of the department's review and analysis of physician incentive plans in a sample of HMOs showed a "wide variety of incentive plans." There were differences in the types of incentive payments, the

distribution of incentives, the basis for determining the incentive payments, and the parties or entities the incentive affected. 61 Fed. Reg. 13432 (March 1996).

An HMO may be an insurance plan only, or it may consist of an insurance plan, a group of health care providers and a hospital, or some combination of these. CIGNA, for example, is an insurance plan which hires its own physicians but contracts with independent hospitals. A large combination-type HMO is Kaiser-Permanente, a company which provides insurance, hires the physicians and other care providers, and owns the clinics and hospitals where the care takes place.¹ Kaiser-Permanente doctors can order any tests, medications, medical procedures or referrals they need *without approval from someone in the health plan*. Physicians have full authority to make health care decisions with their patients.² (emphasis added). Permanente physicians are devoted full time to serving only Kaiser-Permanente members . . . *Individual physicians are compensated on a salaried basis and do not have an incentive to ration care*.³ (emphasis added).

Here 100% of the stock of Health Alliance is owned by the Carle physicians. The stock of Humana, Inc., one of the nation's largest managed care companies, is publicly traded. In his 1998 annual report to shareholders, Humana chairman, David A. Jones, reported that Humana, Inc.'s net income for

1. <http://www.canceronline.org/009-the-ideal.html>.

2. <http://www.kaiserpermanente.org/healthplans/doctorshands.html>.

3. <http://www.kaiserpermanente.org/newsroom/structure.html>.

1998 was \$213 million or \$1.27 per share for Humana's more than 167 million outstanding shares of stock.⁴

The corporate structure of Kaiser-Permanente is completely different from the corporate structure of Health Alliance. The corporate structure of Humana is completely different from the corporate structure of Health Alliance. The only uniform statement that can be made about the great variety of HMOs, is that there is no uniformity. Here there is absolutely no basis for petitioners or Justice Easterbrook to conclude that the Court of Appeals' decision, which was limited to the specific facts of this case, applies to *any* other HMO, much less all other HMOs.

C. Court of Appeals' Decision Does Not Equate Medical Malpractice With Breach of Fiduciary Duty

As in their motion for rehearing *en banc*, petitioners argue here that mere medical malpractice is tantamount to a breach of fiduciary duty under the Court of Appeals' ruling. Petitioners are incorrect. Medical malpractice does not constitute a breach of ERISA fiduciary duties merely because the defendant doctor is part of an HMO. In fact, here the medical malpractice portion of respondent's suit is not even before this Court. As determined by the magistrate in his ruling on petitioners' motion to dismiss amended Count III, "defendants' move to dismiss arguing that Count 3 fails to state a claim under ERISA, and that the new claim is totally unrelated to the original claim for medical negligence." (Pet. App. 62a). After successfully arguing at the trial court level that amended Count III should be dismissed due, in part, to the fact that it is totally unrelated to the remaining malpractice counts, petitioners cannot be permitted to argue

4. <http://www.humana.com/investor/1998annual/letter.html>.

that the Court of Appeals' opinion somehow "blurs" the distinction between traditional medical malpractice and breach of fiduciary duties under ERISA.

II.

COURT OF APPEALS' DECISION DOES NOT CONFLICT WITH THE DECISIONS OF THIS COURT, NOR WITH THE DECISIONS OF OTHER COURTS.

A. Court of Appeals' Decision Complements, Rather Than Abrogates, Legislation Enabling Health Maintenance Organizations

Citing 42 U.S.C. § 300(e) and 42 C.F.R. § 417.479, petitioners state that the Court of Appeals decision effectively bypasses express congressional authorization of HMOs. (Pet. 10, 17). This is incorrect. 42 U.S.C. § 300(e) is merely enabling legislation. Respondent here does not dispute that HMOs are legally authorized. But the issue is not whether HMOs are legally authorized, nor whether cost-containment incentives in general are permissible. The issue presented here is whether this particular corporate structure and cost-containment incentive scheme violate ERISA.

Petitioners are correct in stating that 42 C.F.R. § 417.479 addresses the issue of cost-containment incentives for HMOs receiving Medicare or Medicaid payments. But as stated above, because Count III was dismissed at the pleading stage, no evidence was presented as to whether Health Alliance was federally qualified and participating in Medicare and Medicaid. As a consequence, there is no evidence as to whether 42 C.F.R. § 417.479 even applies to Health Alliance. But more importantly, there is no conflict between the

decision of the Court of Appeals and 42 C.F.R. § 417.479, which was promulgated by the United States Department of Health & Human Services' Health Care Financing Administration. Both the Court of Appeals and H.C.F.A. recognized and were sensitive to the problems inherent in a cost-containment incentive scheme. In order to qualify for Medicare or Medicaid payments, an HMO's contract with H.C.F.A. must specify that the HMO may operate a physician incentive plan *only* if no specific payment is made directly or indirectly under the Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee, and only if further disclosure requirements of H.C.F.A. are met. In point of fact, the rules and regulations adopted by H.C.F.A. attempt to address the very issues addressed by the Court of Appeals in its decision. The H.C.F.A. rules and regulations are perfectly consistent with the ruling of the Court of Appeals.

B. Petitioners are Clearly Fiduciaries Under ERISA

Petitioners suggest that the Court of Appeals decision is inconsistent with this Court's decisions in *Hughes Aircraft Co. v. Jacobson*, ___ U.S. ___, 119 S. Ct. 755 (1999) and *Lockheed Corp. v. Spink*, 517 U.S. 882, 116 S. Ct. 1783 (1996). But neither the *Hughes Aircraft* case nor the *Lockheed* case is applicable to the case at bar. *Hughes Aircraft* involved the amendment of a pension plan and did not involve fiduciary duties concerning administration of the Plan's assets. In *Hughes Aircraft*, this Court was quick to point out that ERISA provides an employer with broad authority to amend a benefit plan, and that, given the employer's obligation to make up any shortfall, no member of a defined benefit plan under ERISA has a claim to any particular asset that composes a part of the Plan's general asset pool.

Like *Hughes Aircraft*, the *Lockheed* case involved a lawsuit against the employer-sponsor of a pension plan. The case at bar does not involve a pension plan, and the plan sponsor, State Farm Insurance, is not even a party to this lawsuit. But more importantly, this Court's ruling in *Lockheed* (plan sponsors who alter the terms of a plan do not fall into the category of fiduciaries) is completely irrelevant where, as here, petitioners have declared themselves to be ERISA fiduciaries and have obtained beneficial rulings based up on that status.

Moreover, the ruling of the Court of Appeals is consistent with a number of other federal court decisions that specifically address HMOs and healthcare plans as opposed to pensions. In *Biomet v. Black*, ___ F. Supp. 2d ___, (N.D. Ind. 1999), the Biomet Health Benefit Plan filed a complaint against one of its participants to enforce a subrogation lien for medical payments of \$91,006.02 made for injuries sustained in a motor vehicle accident. The employee-participant sought dismissal of the complaint on the basis that the Health Benefit Plan was not a "participant, beneficiary or fiduciary" under § 501(a)(3). The District Court disagreed, holding that the Health Benefit Plan was a fiduciary, relying in part on *Health Cost Controls v. Bichanich*, 968 F. Supp. 396 (N.D. Ill. 1997). In *Bichanich*, the Plan itself was not seeking to enforce its subrogation rights. Rather, a collection agency, Health Cost Controls, was seeking to recover on behalf of the Plan. The Court for the Northern District of Illinois specifically ruled that, by definition, an asset is anything of value to the Plan. The ability to recover benefits previously paid out is unquestionably valuable to the Plan; that Health Cost Controls exercised substantial discretion over these plan assets and was, therefore, a fiduciary under ERISA. *See also*

O'Reilly v. Ceuleers, 912 F.2d 1383 (11th Cir. 1990); *Moralis v. Health Plus, Inc.*, 954 F. Supp. 464 (D.P.R. 1997) (an HMO can be an ERISA fiduciary when it exercises discretionary authority or discretionary responsibility in the administration of the healthcare plan). Petitioners do not cite a single decision of any lower court that is in conflict with the 7th Circuit's decision here. There is no reason to use this case as vehicle to resolve the issue of whether HMOs breach any fiduciary duties under ERISA by implementing cost containment incentives.

Petitioners and Justice Easterbrook accuse the Court of Appeals of "stretching" the definition of fiduciary. Even ignoring petitioner's own assertion that they are fiduciaries, it is relatively clear that neither petitioners nor Justice Easterbrook are conversant with the current state of the law on this topic.

CONCLUSION

The petition for certiorari should be denied.

Respectfully submitted,

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APPENDIX

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**APPENDIX A — ORDER OF THE UNITED STATES
DISTRICT COURT FOR THE CENTRAL DISTRICT
OF ILLINOIS, PEORIA DIVISION DATED AND
FILED MAY 13, 1996**

**IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION**

No. 94-1143

CYNTHIA HERDRICH,

Plaintiff,

vs.

LORI PEGRAM and CARLE CLINIC ASSOCIATION,
HEALTH ALLIANCE MEDICAL PLANS, INC.

Defendants.

ORDER

Before this Court is Plaintiff's Motion to Remand [#43], which the Defendants oppose. For the reasons stated herein, this Court DENIES the Motion to Remand.

Plaintiff filed a two-count complaint in State court on October 21, 1992. Count I alleged medical negligence against Defendant Lori Pegram for failing to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II seeks to hold Carle Clinic Association ("Carle Clinic") liable under the theory of respondeat superior.

Appendix A

Herdrich filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("Health Alliance") in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq.* Count IV charged that Health Alliance breached its duty of good faith and fair dealing.

The Defendants filed a Notice of Removal with this Court on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Herdrich filed a Motion to Remand on April 8, 1994. On July 22, 1994, Magistrate Judge Robert J. Kauffman recommended the Motion to Remand be denied. This Court adopted the Magistrate's Report and Recommendation and denied the Motion to Remand on August 5, 1994.

Thereafter, Defendants moved for summary judgment as to Counts III and IV. In an Order dated July 25, 1995, this Court granted the motion for summary judgment as to Count IV. The Order also found that ERISA preempted Count III, and that Herdrich would have to amend her complaint as Count III did not state a claim under ERISA.

Herdrich filed an Amended Count III on September 1, 1995. On November 14, 1995, Defendants filed a Motion to Dismiss Amended Count III. On March 26, 1996, Magistrate Judge Kauffman granted the Motion to Dismiss in a Report and Recommendation and granted Herdrich leave to file an

Appendix A

amended Count III. Herdrich appealed the Magistrate Judge's ruling under Federal Rule of Civil Procedure 72. This Court adopted the recommendation and granted Herdrich leave to file a second amended Count III.

Herdrich then filed her Motion to Remand. In her Motion, she states, "Plaintiff will not further amend her ERISA count (Count III), but rather chooses to stand on those pleadings." She then argues that this Court should remand the matter because this Court lacks jurisdiction to consider the underlying medical malpractice actions.

Defendants oppose the Motion to Remand and argue that this Court should retain jurisdiction under 28 U.S.C. § 1367. Counsel for the Defendants has represented that Herdrich will appeal this Court's April 15, 1996 ruling granting the Motion to Dismiss if the Motion for Remand is granted. Section 1367 provides, in relevant part:

(a) [T]he district courts shall have supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution.

* * *

(c) The district courts may decline to exercise supplemental jurisdiction over a claim under subsection (a) if —

(1) the claim raises a novel or complex issue of State law,

Appendix A

(2) the claim substantially predominates over the claim or claims over which the district court has original jurisdiction, [or]

(3) the district court has dismissed all claims over which it has original jurisdiction.

28 U.S.C. § 1367.

In the case at bar, the medical malpractice claims do not present novel or complex issues of state law. Subsection (2) does not apply to this matter as the federal claims have fallen out of the suit. Finally, this Court has dismissed all claims over which it had original jurisdiction. This litigation is over two years old and judicial economy would not be served by remanding the matter to State court. Moreover, if Herdrich decides to appeal this Court's April 15, 1996 Order, the Defendants would be fighting this battle on two fronts: in the Court of Appeals and in State court. This Court finds that both judicial economy and fairness will be served by retaining Counts I and II.

For the reasons set forth herein, this Court DENIES the Motion to Remand [#43]. This matter is referred to Magistrate Judge Kauffman.

ENTERED this 13th day of May, 1996.

s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

**APPENDIX B — ORDER OF THE UNITED STATES
DISTRICT COURT FOR THE CENTRAL DISTRICT
OF ILLINOIS, PEORIA DIVISION DATED AND
FILED JULY 25, 1995**

**IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION**

No. 94-1143

CYNTHIA HERDRICH,

Plaintiff,

vs.

LORI PEGRAM and CARLE CLINIC ASSOCIATION,
HEALTH ALLIANCE MEDICAL PLANS, INC.

Defendants.

ORDER

Before the Court are Defendants' Motion for Summary Judgment [#16] and Plaintiff's Motion for Leave to File Amended Complaint [#22]. For the reasons set forth herein, the Motion for Summary Judgment is GRANTED in part and DENIED in part. The Motion for Leave to File Amended Complaint is GRANTED in part and DENIED in part.

Factual Background

Plaintiff filed a two count complaint in State court on October 21, 1992. Count I alleged medical negligence against

Appendix B

Defendant Lori Pegram ("Pegram") for failing to adequately examine, treat, and follow-up on Plaintiff's complaint of right, lower quadrant pain. She claims that Pegram's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II seeks to hold Carle Clinic Association ("Carle Clinic") liable under the theory of respondeat superior. Defendants Pegram and Carle Clinic filed an Answer to the State court complaint on December 8, 1992.

Herdrich filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("Health Alliance") in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 et seq. Count IV charges Health Alliance breached its duty of good faith and fair dealing. All of the Defendants filed a Notice of Removal with this Court on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. §1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. §1367. Herdrich filed a Motion to Remand on April 8, 1994.

Her Motion to Remand argued that ERISA did not preempt Counts III and IV of her State court complaint because the State laws at issue did not relate to an employee benefit plan. Plaintiff asserted that Counts III and IV were merely related to employee benefits generally. ERISA's preemption provision provides, in relevant part,

Appendix B

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State law insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title . . .

29 U.S.C. § 1144(a). She maintained that State law actions which are merely incidentally connected to an employee welfare benefit plan are not preempted by ERISA, citing *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 108 S.Ct. 2182 (1988). She concluded that Counts III and IV of her Complaint only indirectly affected the administration of a plan, in that her claims arose out Defendants' business decisions and therefore were not preempted.

In opposition to the Motion to Remand, Defendants argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, Defendants set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. The factual synopsis also asserted that Defendant Health Alliance was the administrator and fiduciary of the Plan. Finally, Defendants contended that as part of the Plan, Health Alliance contracted with Carle Clinic to provide medical care to Plan participants in accordance with an agreed upon fee schedule. In response to Herdrich's legal argument that Count IV was not preempted because it lacked the necessary relationship to an employee benefit plan,

Appendix B

Defendants maintained that plaintiff's reference to the Plan and Health Alliance's duty in her Addendum to the Complaint evidenced a relation between Count IV and the employee welfare benefit plan.

On July 22, 1994, Magistrate Judge Robert J. Kauffman recommended the Motion to Remand be denied. (Report and Recommendation, at 1). The Magistrate Judge found that Count IV related to an employee welfare benefit plan, and as such, was preempted by ERISA. *Id.* at 2-3. The Magistrate did not find specifically that Count III was preempted. Neither party filed objections to the Magistrate's Report and Recommendation, and this Court adopted the Magistrate's Report and Recommendation, denying the Motion to Remand on August 5, 1994.

Discussion

A motion for summary judgment will be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party has the responsibility of informing the court of portions of the record or affidavits that demonstrate the absence of a triable issue. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 2552 (1986). The moving party may meet its burden of showing an absence of material facts by demonstrating "that there is an absence of evidence to support the non-moving party's case." *Id.*, at 325, 106 S.Ct. at 2553. Any doubt as to the existence of a genuine issue for trial is resolved against the moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 2513 (1986); *Cain v. Lane*, 857 F.2d 1139, 1142 (7th Cir. 1988).

Appendix B

If the moving party meets its burden, the non-moving party then has the burden of presenting specific facts to show that there is a genuine issue of material fact. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S.Ct. 1348, 1355-56 (1986). Federal Rule of Civil Procedure 56(e) requires the non-moving party to go beyond the pleadings and produce evidence of a genuine issue for trial. *Celotex Corp.*, 477 U.S. at 324, 106 S.Ct. at 2553. This Court must then determine whether there is a need for trial — whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may be reasonably resolved in favor of either party. *Anderson*, 477 U.S. at 250, 106 S.Ct. at 2511.

Defendants submit that the Plan, through a subscription issued by Carle Clinic Health Maintenance Organization (Carle HMO), provided health and medical benefits to its participants and qualifies as an ERISA plan pursuant to 29 U.S.C. §1001 *et seq.* Defendants assert that Plaintiff's contract with Health Alliance resulted solely from her enrollment in the Plan. Defendants contend, and Plaintiff does not deny, that all benefits provided for under the Plan were paid. Defendants state, without reference to supporting material, that Carle HMO acts as the fiduciary of the Plan. However, the Defendants also frame the issues contained in the Motion for Summary Judgment as "whether an ERISA plan participant/beneficiary may sue an ERISA plan fiduciary under Illinois common law and under the Illinois Consumer Fraud Act, 815 ILCS 505/1, *et seq.*, to recover extra-contractual damages," indicating that Carle Clinic and Health Alliance function as fiduciaries. This statement, taken in conjunction with the prior representations made by

Appendix B

Defendants, indicates that there are three fiduciaries of the Plan: Carle Clinic, Health Alliance, and Carle HMO. Defendants' primary argument in support of its Motion for Summary Judgment, as to Count IV, is that regardless of who functions as the fiduciary, Plaintiff is not entitled to extracontractual damages under ERISA.

Herdrich claims that the Motion for Summary Judgment is "vague and ambiguous." She contends that Carle HMO is a product, not an entity and as such cannot qualify as a fiduciary under 29 U.S.C. §1002(21)(A). She also submits that Carle Clinic is not a fiduciary as a matter of law and Defendants have failed to present evidence which supports their assertion that Carle Clinic is a fiduciary. Further, she argues that Health Alliance does not appear to be a fiduciary of the Plan as a matter of fact. In support of this contention, Herdrich cites to Health Alliance's 1992 Annual Statement, filed with the Illinois Department of Insurance, which states that Health Alliance is not a "provider of administrative services or 'stop loss' group accident and health insurance to a multiple employer trust or multiple employer welfare arrangement." Herdrich submits that Carle Health Insurance Management Company ("CHIMCO") is, in fact, the fiduciary of the Plan. This Court will first address the issues raised by the parties in terms of Count IV, as neither the Magistrate Judge nor this Court have determined that Count III is preempted by ERISA. Then this Court will determine, for purposes of jurisdiction, whether Count III is preempted by ERISA.

Appendix B

A. Count IV

As there are serious questions about which organization(s) function as the fiduciary, this Court must determine whether this Plaintiff can recover the type of damages she seeks in Count IV, regardless of who exists as the fiduciary. Herdrich submits that ERISA provides for extracontractual damages in §502(a)(3). Plaintiff cites *Blue Cross and Blue Shield of Alabama v. Lewis*, 753 F.Supp. 345, 347 (N.D.Ala. 1990), for the proposition that §502(a) of ERISA allows for extracontractual, even punitive damages. Herdrich concedes, however, that the Seventh Circuit does not follow the holding in *Lewis*, stating that "[i]t is doubtful that the Seventh Circuit's refusal to follow the ruling of the Alabama District Court is justified since the Seventh Circuit apparently ignored the intent of Congress." (Mem. in Opposition to Summary Judgment, at 4).

Defendants cite the Supreme Court's holding in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985), for the proposition that ERISA prohibits the award of extracontractual damages. ERISA's civil enforcement provision, § 502(a) provides, in relevant part,

A civil action may be brought —

- (1) by a participant or beneficiary —
- (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the

Appendix B

terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of his plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a). Section 409, entitled Liability for breach of fiduciary duty states, in part,

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other

Appendix B

equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a).

In *Russell*, the plaintiff received benefits under an employee welfare benefit plan for a back injury from May 1979 until October 17, 1979 when an orthopedic surgeon reported that the plaintiff was no longer disabled. *Russell*, 473 U.S. at 136. The plaintiff requested a review of the termination of her benefits and proffered a report from her psychiatrist "... indicating that she suffered from a psychosomatic disability with physical manifestations rather than an orthopedic illness." *Id.* When this report was confirmed by a second psychiatrist, the plan administrator reinstated plaintiff's benefits — including a retroactive payment. *Id.* The plaintiff's suit, brought under § 502(a)(2), alleged that she sustained an injury "by the improper refusal to pay benefits from October 17, 1979, when her benefits were terminated, to March 11, 1980, when her eligibility was restored." *Id.*

The Court granted certiorari "to review both the compensatory and punitive components of the Court of Appeals holding that § 409 authorizes recovery of extracontractual damages." *Id.* at 138. The Court held that § 502(a)(2) authorizes a plan beneficiary to bring suit against a fiduciary under § 409. Any recovery for a breach of fiduciary duty, however, "inures to the benefit of the plan as a whole." *Id.* at 140. Further, the Court's decision states that within the context of §§ 502(a)(2) and 409, "we do not find in § 409 express authority for an award of extracontractual

Appendix B

damages to a beneficiary." *Id.* at 144. The Court did not address whether a plan could recover extracontractual damages from a fiduciary under § 409. *Id.* at n.12.

The Court noted that because the plaintiff relied "... entirely on §409(a), and expressly disclaimed reliance on §502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extracontractual damages." *Id.* at 139, n.5. Therefore, regardless of the identity of the fiduciary, to the extent that Plaintiff seeks recovery of extracontractual damages under §§ 502(a)(2) and 409(a), summary judgment is granted in favor of the Defendants.

The plaintiff in *Russell* also argued that a private right of action for extracontractual damages should be implied absent an express authorization by ERISA. *Russell*, 473 U.S. at 145. The Court looked to the four-factor test employed by *Cort v. Ash*, 422 U.S. 66, 78 (1975), to determine whether an implied right of action for extracontractual damages exists under ERISA. *Id.* at 145. The Court declined to extend the *Ash* decision to "authorize the recovery of extracontractual damages. Because 'neither the statute nor the legislative history reveals a congressional intent to create a private right of action.'" *Id.* at 148 (quoting *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 94, n.31 (1981)). To the extent Herdrich argues for an implied right of action for extracontractual damages, the *Russell* case controls. No such right exists.

As the *Russell* decision left open the issue of whether §502(a)(3) would permit recovery of extra-contractual

Appendix B

damages, this Court must now turn to Plaintiff's argument that after the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990), 502(a)(3) should be found to allow for the recovery of extracontractual damages by a plan beneficiary. In *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), *cert. denied*, 113 S.Ct. 61 (1992) the plaintiffs filed a suit against their employer, a law firm, and the employee welfare benefit plan to which they belonged. *Harsch*, 956 F.2d at 652-53. The plaintiffs alleged that their employer "had refused to comply with the plaintiffs' written request for information and claims for benefits, in violation of the terms of the plan, the policy and practices of the firm, and ERISA" and sought compensatory and punitive damages. *Id.* at 653. In holding that neither §502(a)(1)(B) nor §502(a)(3)(B) provided for compensatory damages, the *Harsch* court discussed the impact of *McClendon* on the *Russell* holding. *Id.* at 655, 659-660. The Seventh Circuit focused on the last paragraph of the *McClendon* opinion which states:

[T]here is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek "pension benefits." It is clear that the relief requested here is well within the power of the federal courts to provide. Consequently, it is no answer to a preemption argument that a particular plaintiff is not seeking the recovery of pension benefits.

Id. at 659 (quoting *McClendon*, 111 S.Ct. at 486). After summarizing the post-*McClendon* case law, including *Blue Cross and Blue Shield v. Lewis*, *supra*, the case our Plaintiff

Appendix B

relies upon, and *International Union, United Automobile, Aerospace and Agricultural Implement Workers v. Midland Steel Products Co.*, 771 F.Supp. 860, 863 (N.D. Ohio 1991), the Seventh Circuit concluded that the dicta from *McClendon* did not authorize the recovery of compensatory damages under § 502(a)(3). *Id.* at 660 (“we are not rash enough to believe that the Court intended to overrule settled law in most of the circuits, as well as narrowly limit — if not overrule — its own decision in *Russell* in such an off-hand manner”).

As to the availability of punitive damages under either § 502(a)(1)(B) or § 502(a)(3), the *Harsch* court found neither section of ERISA allowed for punitive damages. *Id.* at 661. Specifically as to § 502(a)(3), the court cited its prior holding in *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987) (punitive damages are not available under § 502(a)(3)). Other courts have relied upon *Harsch* in finding that § 502(a)(3) does not provide for extracontractual damages. See e.g. *Lafov v. HMO Colorado*, 988 F.2d 97, 99 (10th Cir. 1993); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 32 (5th Cir. 1993); *Zimmerman v. Sloss Equipment, Inc.*, 835 F.Supp. 1283, 1291 (D.Kan. 1993); *Pension Plan of Public Service Assoc. of New Hampshire et al. v. KPMG Peat Marwick*, 815 F.Supp. 52, 56-57, n.2 (D.N.H. 1993). Although Herdrich suggests that the Seventh Circuit’s decision in *Harsch* is an incorrect reading of *Russell* and *McClendon*, this Court chooses to follow the Seventh Circuit’s well reasoned holding.

Additionally, the Supreme Court has recently elaborated on the reference in § 502(a)(3)(B) to “other appropriate

Appendix B

equitable relief.” *Mertens v. Hewitt Assoc.*, 113 S.Ct. 2063 (1993). The Court granted certiorari to answer the question “. . . whether ERISA authorizes suits for money damages against non-fiduciaries who knowingly participate in a fiduciary’s breach of fiduciary duty.” *Id.* at 2066. In determining that a beneficiary may not recovery monetary damages from a non-fiduciary, the Court held that § 502(a)(3)(B) included typical remedies available in equity and not “legal remedies” like compensatory damages or monetary relief. *Id.* at 2069. The *Mertens* decision was limited to the type of damages which may be recovered under § 502(a)(3). *Anweiler v. American Elec. Power Service Corp.*, 3 F.3d 986, 993 (7th Cir. 1993). Thus, *Mertens* gives further support to this Court’s conclusion that to the extent Herdrich relies on § 502(a)(3)(B) as a basis for monetary relief, as opposed to equitable relief, she may not proceed as a matter of law. This Court finds that plaintiff’s claim for extracontractual damages against Defendant Health Alliance may not, as a matter of law, survive summary judgment. As this Court’s finding is not specific to Health Alliance, but may be applied to any fiduciary, Plaintiff’s Motion for Leave to Amend is denied as to Count IV.

B. Count III

As the Magistrate Judge left open the question of whether Count III of Plaintiff’s Complaint is preempted, this Court must determine, as a jurisdictional matter, whether Count III is preempted by ERISA. If not, the matter should be remanded to State court. As set forth above, Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance in violation of

Appendix B

the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq.* Specifically, Plaintiff claims that Carle Clinic sold her a subscription in Carle HMO through its wholly owned subsidiary Health Alliance. Plaintiff maintains that Defendant Carle Clinic violated the Consumer Fraud act by failing to advise her that the Carle HMO physicians hired by Health Alliance, in fact owned Health Alliance. Plaintiff also avers that Defendant Carle Clinic failed to inform her that the compensation of Carle HMO physicians was "increased to the extent that those physicians did not order diagnostic tests; did not utilize facilities not owned by those physicians; and did not make emergency or consultation referrals." (Addendum to Complaint, at 2). Count III seeks an amount in excess of \$15,000.00 plus costs and attorney fees.

In ERISA's §1, Congress articulated its declaration of policy, stating: "... to provide for the general welfare and free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans." 29 U.S.C. § 1001(a). In ERISA, Congress set out to

protect . . . participants in employee benefit plans . . . by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts.

Appendix B

29 U.S.C. § 1001(b). Herdrich's claim in Count III is essentially that Defendants failed to disclose relevant, material information regarding the operation of the Plan. In order to find Count III preempted by ERISA, the State law which forms the basis of the claim must "relate to" an employee welfare benefit plan. 29 U.S.C. § 1144(a). The Supreme Court has given a broad interpretation to the "relate[s] to" requirement. In *Shaw v. Delta Air Lines*, 463 U.S. 85, 97, 103 S.Ct. 2890, 2900 (1983), the Court held that "a law 'relates to' an employee benefit plan in the normal sense of the phrase, if it has a connection with or reference to such plan." *Shaw*, 463 U.S. at 97.

ERISA contains detailed disclosure requirements. In § 101, the statute requires the administrator of each employee benefit plan to provide all participants with a summary plan description and fiscal statements and schedules. 29 U.S.C. § 1021(a) The summary plan description must include the following:

The name and type of administration of the plan, the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator, names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of an applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension

Appendix B

benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part.

29 U.S.C. § 1022(b). Additionally, ERISA requires each employee benefit plan publish an annual report, which is to be filed with the Secretary and made available to the plan participants and beneficiaries. 29 U.S.C. §§ 1023(a)(1)(A) and 1024(a) & (b). The annual report must contain a financial statement and opinion. 29 U.S.C. § 1023(a)(1)(B)(i). The financial opinion must issue from an independent qualified public accountant. 29 U.S.C. § 1023(a)(3)(A). The financial statement must include "a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position." 29 U.S.C. § 1023(b)(1). The notes accompanying the financial statement must contain the following disclosures:

[A] description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with

Appendix B

person known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of the plan.

29 U.S.C. § 1023(b)(1). ERISA also dictates the schedules which must be attached to the financial statements. 29 U.S.C. § 1023(b)(3). The annual report must also contain an actuarial statement and opinion prepared by an enrolled actuary. 29 U.S.C. § 1023(a)(4)(A)

It is apparent from this brief review of ERISA's disclosure requirements that the statute comprehensively regulates the necessary disclosures. Count III seeks to impose additional disclosure requirements on the plan administrator other than those which are expressly enumerated in ERISA. This Court finds that under the broad reach of ERISA's § 514, Plaintiff's Count III relates to an employee benefit plan, and as such is preempted.

Having found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be provide a cause of action for Plaintiff. The availability of a federal remedy does not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA. *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989). Plaintiff is given leave to submit an amended Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision. If Plaintiff declines this opportunity,

Appendix B

Count III will be dismissed with prejudice, and the remaining matters will be remanded to State Court.

Conclusion

For the reasons stated herein, the Motion for Summary Judgment as to Count IV is GRANTED in favor of Defendant Health Alliance Medical Plans, Inc. with costs. The Motion for Summary Judgment as to Count III is DENIED. The Plaintiff has fourteen (14) days to file her amended Complaint as to Count III, specifying under which of ERISA's civil enforcement provisions she intends to proceed. IT IS SO ORDERED.

ENTERED this 25th day of July, 1995.

s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

**APPENDIX C — MEMORANDUM IN OPPOSITION
TO PLAINTIFF'S MOTION TO REMAND**

**IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION**

No. 94-1143

CYNTHIA HERDRICH,

Plaintiff,

vs.

LORI PEGRAM and CARLE CLINIC ASSOCIATION,
HEALTH ALLIANCE MEDICAL PLANS, INC.

Defendants.

**MEMORANDUM IN OPPOSITION TO
PLAINTIFF'S MOTION TO REMAND**

Introduction

Defendants, Lori Pegram, M.D., Carle Clinic Association, and Health Alliance Medical Plans, Inc., removed this case on March 14, 1994. The state trial court in the Eleventh Circuit of Illinois, McLean County, had allowed the plaintiff to amend her pleadings on February 18, 1994. The new allegations, Counts III and IV, for the first time, raise claims which relate to an employment benefit plan, as defined and preempted by Section 514(a) of ERISA (29 U.S.C. Section 1144(a)(1988)). The original complaint,

Appendix C

Counts I and II failed to adequately set forth a claim or right arising under the Constitution, treaties or laws of the United States, in that they stated a claim for professional negligence against Lori Pegram, M.D. (Count I) and *respondeat superior* against Carle Clinic Association (Count II).

After receipt of plaintiff's Addendum to the Complaint as stated above, the defendants were, for the first time, put on notice that the plaintiff was asserting an action which was removable to this Court since the Addendum, for the first time, brought a claim over which this Court has original jurisdiction of the provisions of Title 28, U.S.C., Section 1441(b) and Title 29, U.S.C., Section 1144(a). Removal of this matter was, therefore, timely. Plaintiff has not raised timeliness as an objection to the removal.

Rather, plaintiff asserts in the motion to remand and supporting memorandum, that the claims set forth in Counts III and IV of the Addendum to the complaint do not "relate to" any employee benefit plan . . . as set forth in Section 514(a) of ERISA.

Synopsis of Relevant Facts

The plaintiff, Cynthia Herdrich, was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her by her husband's employer, State Farm Insurance Companies. Defendant, Health Alliance Medical Plans, Inc. ("Health Alliance") was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. Section 1001 et seq.)

Appendix C

As part of the Plan, Health Alliance entered into a contract with Carle Clinic Association ("Carle") in which Carle agreed to provide medical care to participants in the Plan in accordance with an agreed upon fee schedule. Defendant, Dr. Lori Pegram, is an employee of the Carle Clinic Association. In March of 1991, Cynthia Herdrich has alleged she was suffering from right, lower quadrant pain resulting from appendicitis. She was seen by Dr. Pegram on March 1, 1991. On March 7, 1991, plaintiff's appendix perforated. On March 15, 1991, plaintiff underwent a successful exploratory laparotomy.

This action was commenced in state court on October 21, 1992. The original action was for the alleged malpractice of Dr. Pegram and under a theory of *respondeat superior*, Carle Clinic Association. Initially they were the only defendants.

In February of 1994, the plaintiff was allowed leave to file an Addendum to the Complaint, which for the first time, added Health Alliance Medical Plans, Inc. as an additional defendant. For the first time, plaintiff alleged that Carle Clinic, P.C., violated the Illinois Consumer Fraud Act (815 ILCS 505/1 et seq.) by allegedly failing to advise the plaintiff that the Carle Care HMO physicians hired by Health Alliance in fact owned Health Alliance and failed to advise plaintiff that the compensation of the Carle Care HMO physicians hired by Health Alliance was increased to the extent that those physicians did not order diagnostic tests; did not utilize facilities not owned by those physicians; and did not make emergency or consultation referrals. It was further alleged, for the first time, that Health Alliance breached a duty of

Appendix C

good faith and fair dealing in arranging medical and hospital services by having its contracted physicians minimize the use of diagnostic tests, the facilities not owned by those physicians, and the emergency consultation referrals.

Federal Preemption

The United States Constitution provides that "The Laws of the United States . . . shall be the supreme Law of the Land . . . anything in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. Thus, since *McCulloch v. Maryland*, 17 U.S. 316, 427 (1819) (Wheat.), state law that conflicts with federal law has no effect. *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981). However, Supremacy Clause analysis "start[s] with the assumption that the historic police powers of the states [are] not to be superseded by Federal Act *unless that [is] the clear and manifest purpose of Congress*". *Rice v. Santa Fe Elevator Corporation*, 331 U.S. 218, 230 (1947) (emphasis added). Accordingly, the purpose of Congress is the "ultimate touchstone" of preemption analysis. *Malone v. White Motor Corporation*, 435 U.S. 497, 504 (1978) (quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)).

Congress' purpose may be stated explicitly in a statute's language or contained implicitly in the statute's structure and purpose. *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). For example, state law is preempted if it actually conflicts with federal law, even in the absence of an express Congressional command. *Pacific Gas & Electric Co. v. Energy Resources Conversation and Dev. Comm'n.*, 461 U.S. 190, 204 (1983). State law also is preempted if federal law

Appendix C

"so thoroughly occupies a legislative field as to make reasonable the inference that Congress left no room for the states to supplement it." *Fidelity Federal Savings & Loan Association v. De la Cuesta*, 458 U.S. 141, 153 (1982). Both of these principles of preemption apply in the case of ERISA.

ERISA Preemption

Section 514(a) of ERISA provides, in part:

[T]he provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a) of this Title and not exempt under Section 1003(b) of this Title. 29 U.S.C. Section 1144(a)(1988)

The United States Supreme Court, commenting upon the breadth of this provision, described it as a "virtually unique preemption provision." *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983). Congress' purpose in enacting ERISA is the "ultimate touchstone" in determining ERISA preemption. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Congress enacted ERISA to protect employees' anticipated benefits. 29 U.S.C. Section 1001(1988). ERISA's preemption clause protects employee benefit plans from conflicting and inconsistent state laws because such laws may hinder a plan's ability to administer benefits uniformly. *Fort Halifax Packing Co. v. Coyne*, 428 U.S. 1, 8-9 (1987).

Appendix C

There are a number of Supreme Court decisions interpreting ERISA's preemption clause. One of the earliest to find preemption is *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). In *Alessi*, the court included that ERISA preempts a New Jersey statute prohibiting an offset against employee retirement benefits for the amount a retiree received in workers' compensation. In so finding, the court concluded that the New Jersey statute "relates to" pension plans governed by ERISA because it purports to eliminate one method of calculating pension benefits-integration that ERISA permits. The court rejected the suggestion, similarly put forth by the plaintiff here, that New Jersey law intrudes on ERISA only indirectly, through a workers' compensation law, rather than directly, through a "pension regulation." The Court observed:

ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. For the purposes of the pre-emption provision, ERISA defines the term 'State' to include: 'a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, *directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.*' 29 U.S.C. Section 1144(c)(2) (emphasis added).

ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision. *Id.* at 525.

Appendix C

One of the more oft-cited Supreme Court cases on the issue of ERISA preemption is *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). The *Pilot Life* decision is particularly interesting because it concludes that ERISA preempts certain state common-law tort and contract actions that assert improper processing of a claim under an employee benefit plan. *Pilot Life* demonstrates the expansiveness of the meaning of "State law" in Section 514(a) of ERISA, which Congress defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any state." 29 U.S.C. Section 1144(c)(1)(1988).

The Court found in *Pilot Life* there was no dispute that the common-law causes of action in question — tortious breach of contract, breach of fiduciary duties, and fraud in the inducement — "related to" an employee benefit plan. Having reached this conclusion, the Court's only task was to determine whether any of the exemptions to preemption applied. The plaintiff asserted that Mississippi's law of bad faith is a law "which regulates insurance" and thus is saved from preemption by ERISA, Section 514(b)(2)(A), 481 U.S. at 47. The Court rejected this argument, however, noting that Mississippi's bad faith law, while identified with the insurance industry, has its roots in the general principles of Mississippi tort and contract law.

Of particular import to the plaintiff's Addendum to the Complaint here, in which bad faith and fraud are alleged, and the ERISA preemption of same is the discussion of preemption of such claims in *Pilot Life*:

The policy choices reflected in the inclusion of certain remedies and the exclusion of others under

Appendix C

the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in Section 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of the policies embodied in its choice of remedies argues strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. 481 U.S. at 54.

Here, plaintiff's claim of fraud and breach of duty to act in good faith are clearly related to the employment benefit plan. To be sure, plaintiff attaches the subscription agreement to the complaint referencing same in her complaint. The plaintiff states in her Motion for Remand, "ERISA preemption is not triggered by actions which indirectly affect the administration of a benefit plan, but only those that impact directly on primary administrative functions of the plan." It is contended that the allegation of good faith and fair dealing does not "impact on" the employee benefit plan. For this proposition, the plaintiff cites the District Court for the Eastern District of Pennsylvania (*Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D. Pa. 1990)). In essence, plaintiff argues that her claims are not clearly preempted

Appendix C

under Section 514 (29 U.S.C. Section 1144(a)(1988)) because they do not "relate to" an ERISA plan, a precondition to preemption under Section 514. The plaintiff's contention must fail, given the breadth placed upon the term "relates to" by the United States Supreme Court. The United States Supreme Court has stated they have no hesitation to enforce ERISA's preemption provisions where a state law creates the prospect that employer's administrative scheme would be subject to conflicting requirements. *Fort Halifax Packing Co., Inc. v. Coyne*, 42 U.S. 1.

In *First National Life Ins. v. Sunshine-Junior Food Stores*, 960 F. 2d 1546 (11th Cir. 1992) the court held:

Moreover, state contract and tort laws that impose varying standards upon the administrator of a welfare benefit plan create a significant potential for conflict with ERISA and thus are logically preempted. As we noted earlier, Congress deliberately wrote Section 1144(a) in a broad manner in order to make pension plan regulation exclusively a federal concern. 960 F. 2d at 1550.

In this case, as is evidenced by the fact that plaintiff, in her Addendum to the Complaint, has specifically referred to the Plan, and must in order to create any relationship or "duty" between Health Alliance and Cynthia Herdrich, the existence of the Plan is a prerequisite to the plaintiff's state law claims. In other words, absent the existence of the Plan, plaintiff would have absolutely no standing to assert any claim against Health Alliance.

Appendix C

The United States Supreme Court of Appeals for the Eleventh Circuit has similarly held in *Sanson v. General Motors Corp.*, 966 F. 2d 618 (11th Cir. 1992) that when a plaintiff would not have a state law cause of action absent the existence of an ERISA plan, the state law claim is preempted. Clearly, plaintiff's Addendum to the Complaint is based solely and completely upon her contractual relationship to the ERISA plan of Health Alliance. Thus, under the compelling rationale of *Sanson* and *First National Life Insurance* and countless other cases, plaintiff's claims here are preempted.

The plaintiff's reliance on a decision from the Eastern District of Pennsylvania is misplaced. The Pennsylvania Court has, in other decisions, found no preemption. Yet, the underpinning and rationale of those decisions has been specifically rejected by the Seventh Circuit in *Lister v. Stark*, 890 F. 2d 941 (7th Cir. 1989) *cert. den'd.* 111 S. Ct. 579 (1990) and their reasoning rejected again in *Bartholet v. Reishauer A.G. (Zurich)*, 953 F. 2d 1073, 1076-77 (7th Cir. 1992). *See, also, Christopher v. Mobil Oil Corp.*, 950 F. 2d 1209 (5th Cir. 1992); *Bernatowicz v. Colgate Palmolive Co.*, 1992 U.S. Dist. Lexis 2889 (D. N.J. 1992). Not a single federal court has followed or adopted the line of cases from the Eastern District of Pennsylvania. Indeed, every federal court to address these cases has rejected them. The Pennsylvania cases are simply based upon a misunderstanding of the breadth of the term "relate to", a misunderstanding specifically noted and rejected by the Seventh Circuit in *Lister*.

Appendix C

The *Bartholet* court noted when rejecting Bartholet's argument that his claims were not removable because they were not related to an ERISA plan:

Thomas Reed Powell defined the legal mind as one that can think of something inextricably connected to something else, without thinking of what it is connected to. Not even the most segmented mind could contemplate the benefit without the plan.

Indirect Effect on Plan

Plaintiff contends in her Motion for Remand that the state law claims affect the Plan only indirectly. However, this contention, even if true, does not avoid the expansive language of Section 514.

In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 15 EBC 1934 (E.D. Va. 1992), *Aetna* operated a health maintenance agreement (HMO) and was the insurer/administrator of an ERISA plan which provided medical benefits through the HMO. *Aetna* had chosen not to allow Stuart Circle Hospital to participate in the HMO. The hospital sued, attempting to enforce a Virginia statute that provided PPOs could not discriminate against whom they allowed to join.

The District Court held that the state statute was preempted. After reviewing the broad scope of ERISA's preemption provision, the court held:

Appendix C

So long as a state law has a 'connection with or reference to' an employee benefit plan, then the law relates to the plan, and it is of no consequence whether the effect on the plan is direct or indirect. *15 EBC at 1937.*

The court held the Virginia law was preempted.

An Illinois law that allows an ERISA plan administrator/fiduciary to be subject to the liability for directing a patient's healthcare in order to maximize profits for the Plan and affect optimum delivery of care, has both a connection with and affects that Plan directly. A Plan administrator who relies upon the unanimous case law which provides it can be held liable only for those benefits specifically provided in the ERISA plan it administers, could now find itself, as a result of its administering the ERISA plan, facing unlimited liability under state law statutes and theories. In such a scenario, it is ludicrous to argue that such state law claims have no connection to the ERISA plan or that they only affect the ERISA plan indirectly as plaintiff asserts here.

The proposition put forth by the plaintiff in the Motion to Remand was similarly discussed by Justice O'Connor in *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 138 (1991). Justice O'Connor explained:

The preemption clause is conspicuous for its breadth. Its deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern. [citations omitted] The key to Section 514 is found in the words

Appendix C

"relate to." Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause "applicable only to state laws relating to the specific subjects, covered by ERISA." [citation omitted] Moreover, to underscore its intent that Section 514(a) be expansively applied, Congress used equally broad language in defining the "state law" that would be preempted . . . A law "relates to" an employee benefit, in the normal sense of the phrase, if it has a connection with or reference to such plan.

In *Holland v. Burlington Industries, Inc.*, 772 F. 2d 1140 (4th Cir. 1985), *aff'd. sub nom., Brooks v. Burlington Industries, Inc.*, 477 U.S. 903 (1986), the court acknowledged that ERISA was the most sweeping federal preemption statute ever enacted by Congress and, relying upon *Alessi v. Rabestos-Manhattan, Inc.*, 451 U.S. 504 (1981), stated that the only state laws not preempted were those specifically exempted from preemption by Section 514. 772 F. 2d at 1146-47. In the recent case of *Talamine v. Unum Life Insurance Co. of America*, 1992 U.S. Dist. Lexis 14372 (N.D. Ill. September 24, 1992), the court again acknowledged the "sweeping breadth" of Section 514 and noted that the Supreme Court had consistently "expansively interpreted" the preemptive scope of ERISA.

A somewhat more detailed approach was taken by the Eighth Circuit in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital*, 947 F. 2d 1341 (8th Cir. 1991), *cert. den'd.*, 112 S. Ct. 2305 (1992). The court there identified various

Appendix C

factors that should be examined in determining whether or not a plaintiff's claims "relate to" an ERISA plan. Applying each of the factors identified by the Eighth Circuit to the facts of this case, it is clear that Cynthia Herdrich's claims relate to the Plan because her claims would: (1) significantly impact the relationship between Plan participant and Plan administrator as the Plan administrator would become the guarantor of the quality of care paid for by the Plan; (2) would considerably increase the administrative burdens of the Plan who would have to develop and enforce an entirely new and burdensome system whereby it would oversee and guarantee the medical judgments of the physician; (3) substantially increase the cost of administering the Plan by requiring the oversight system described above and by requiring the Plan administrator's budget for risk of breach of claims for breach of bad faith and fair dealing, as well as fraud; (4) dramatically affect the statutory scheme which was intended to assure Plan sponsors and fiduciaries that they would have the freedom to develop their ERISA plans as they choose, thereby limiting their liability.

In the case now before this Court, it is clear that the plaintiff's claims relate to the Plan administered by Health Alliance. The relationship between the plaintiff and Health Alliance arose solely from the Plan. But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and Health Alliance's serving as administrator/fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and Health Alliance and thus no lawsuit.

Moreover, the claims against Carle Clinic, P.C. relating to fraud arise solely out of the relationship between Carle

Appendix C

Clinic, P.C. and the plaintiff and their collective relationship to Health Alliance. In light of the foregoing, the plaintiff cannot seriously contend that her claims are not related to the Plan.

In short, because the plaintiff is a participant/beneficiary of the Plan, and because she is asserting claims related to the Plan against the Plan's fiduciary and administrator, their claims are clearly within the preemption provision of Section 514. *Ingersoll-Rand v. McClendon*, *supra*.

Respectfully Submitted,

LORI PEGRAM, M.D., CARLE
CLINIC ASSOCIATION, and
HEALTH ALLIANCE MEDICAL
PLANS, INC., Defendants,

BY: LIVINGSTON, BARGER,
BRANDT & SCHROEDER

BY:
one of their attorneys

**APPENDIX D — ANNUAL STATEMENT OF
HEALTH ALLIANCE MEDICAL PLANS, INC.**

LIFE AND ACCIDENT AND HEALTH COMPANIES —
ASSOCIATION EDITION

0000779509201400
affix bar code above

ANNUAL STATEMENT

For the Year Ended December 31, 1992
OF THE CONDITION AND AFFAIRS OF THE
Health Alliance Medical Plans, Inc.

NAIC Group Code 000 NAIC Company Code 77950
Employer's ID Number 37-1260731

Organized under the Laws of the State of Illinois, made to
the **INSURANCE DEPARTMENT OF THE STATE OF**

PURSUANT TO THE LAWS THEREOF

Incorporated November 17, 1989 Commenced Business
December 1, 1989

Statutory Home Office 602 W. University Avenue (Street
and Number), Urbana, Illinois 61801 (City or Town, State
and Zip Code)

Main Administrative Office 102 E. Main Street, Suite 200,
P.O. Box 6003 (Street and Number), Urbana, IL 61801 (City
or Town, State and Zip Code) 217 337-8010 (Area Code)
(Telephone Number)

Appendix D

Mail Address 102 E. Main Street, Ste. 200, P.O. Box 6003
(Street and Number or P.O. Box), Urbana, Illinois 61801
(City or Town, State and Zip Code)

Primary Location of Books and Records 102 E. Main Street,
Suite 200 (Street and Number), Urbana, IL 61801 (City or
Town, State and Zip Code) 217 337-8000 (Area Code)
(Telephone Number)

Annual Statement Contact Person and Phone Number
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Appendix D

STATE OF Illinois)
) ss.
 COUNTY OF Champaign)

John R. Pollard MD, President, **Alan K. Hatfield, MD**, Secretary, . . . of the **Health Alliance Medical Plans, Inc.**, being first duly sworn, deposes and says that they are the above described officers of the said insurer, and that on the thirty-first day of December last, all of the herein described assets were the absolute property of the said insurer, free and clear from any liens or claims thereon, except as herein stated, and that this annual statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to are a full and true statement of all the assets and liabilities and of the condition and affairs of the said insurer as of the thirty-first day of December last, and of its income and deductions therefrom for the year ended on that date, and have been completed in accordance with the NAIC annual statement instructions and accounting practices and procedures manuals except to the extent that: (1) state law may differ; or (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively.

s/ John W. Pollard, MD
 President

s/ Alan K. Hatfield, MD
 Secretary

* * *

(a) is this an original filing? yes [x]

* * *

Appendix D

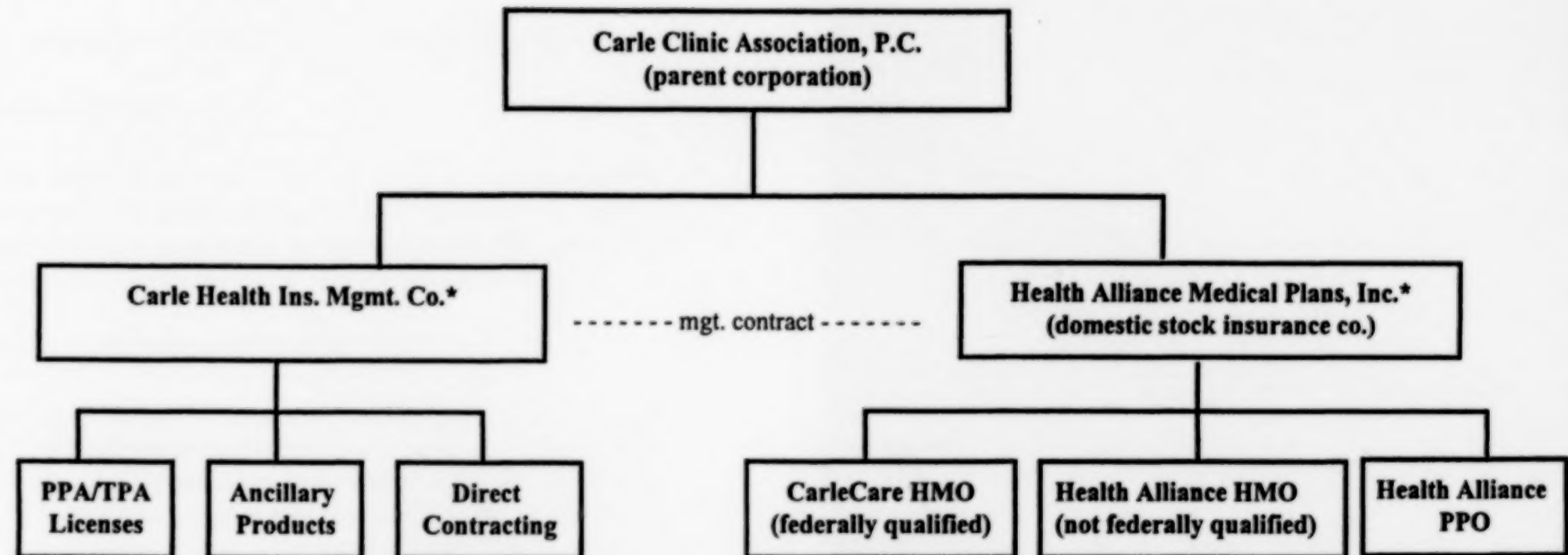
Subscribed and sworn to before
 me this 8th day of March, 1993.

s/ Marsha Diane Eversole
 notary public

42a

**APPENDIX E — PART 1 —
ORGANIZATIONAL CHART**

PART 1 — ORGANIZATIONAL CHART



•for-profit wholly-owned subsidiary of Carle Clinic Association, P.C.

**APPENDIX F — NOTES TO FINANCIAL STATEMENTS
OF HEALTH ALLIANCE MEDICAL PLANS, INC.**

**ANNUAL STATEMENT
OF
HEALTH ALLIANCE MEDICAL PLANS**

NOTES TO FINANCIAL STATEMENTS

1. Basis of Presentation:

The accompanying financial statements have been prepared in conformity with accounting practices prescribed or permitted by the National Association of Insurance Commissioners and the State of Illinois.

2. Basis of Valuation of Invested Assets:

A. Asset values are generally stated as follows: Invested cash includes short-term investments which are stated at cost. Short-term investments totaled \$109,963. Long-term investments are stated at the lower of cost or market value. Long-term investments totaled \$5,841,839. The effective interest method was used for the Amortization of bonds.

B. Purchased computer software is recorded at cost and is amortized using the straight-line method over 3 years. Furniture and equipment is recorded at cost and is depreciated using the MACRS method over periods of 5 and 7 years.

C. Not applicable.

Appendix F

3. Investment Income:

No category of investment income has been deducted or excluded (non-admitted) on any investment.

4. Federal Income Tax Allocation:

A. The Company files a consolidated Income Tax return with the following companies:

Carle Clinic Association
Carle Health Insurance Management Company

B. The Company and the Clinic have agreed that the consolidated tax liability for any given year will be allocated to those companies that have taxable income during such year in proportion to their relative taxable incomes. Similarly, consolidated tax benefits are allocated to those companies that have taxable losses which give rise to the benefit in proportion to their relative taxable losses.

Intercompany tax balances are settled annually in the fourth quarter.

**APPENDIX G — MINUTES OF APRIL 6, 1992 OF
THE ANNUAL MEETING OF HEALTH ALLIANCE
MEDICAL PLANS, INC.**

**MINUTES
HEALTH ALLIANCE MEDICAL PLANS, INC.
ANNUAL MEETING**

The Board of Directors of Health Alliance Medical Plans, Inc. ("Health Alliance") met on Monday, April 6, 1992 at 3:30 p.m. in the North Tower 1 Board Room. The following Directors were present: Drs. Scully, Noonan, Parker, Schrepfer, Hatfield, Kammer, and Pollard; Staff present: Dr. Parker; and Messrs. Bash, Green, and King.

Dr. Scully, Chairman, called the meeting to order and noted that a quorum was present. It was moved, seconded and passed to approve the minutes of the March 18, 1991 Annual Meeting as submitted.

Pursuant to Article III, Section 2 of Health Alliance's corporate bylaws as amended in 1991, an appointment to the Board of Governors of Carle Clinic Association, P.C. results in an automatic appointment to the Board of Directors of Health Alliance. Therefore, no elections at Health Alliance's Annual Meeting are required. Dr. Noonan was recognized as a new Director for the record.

It was moved, seconded, and passed to appoint the following individual as Officers of Health Alliance's Board of Directors:

Robert M. Scully, MD, Chairman
Thomas C. Schrepfer, MD, Vice-Chairman
Terry R. Noonan, MD, Secretary-Treasurer
John W. Pollard, MD, President

Appendix G

It was moved, seconded, and passed to appoint the Corporate Officers of Health Alliance assigned by Carle Health Insurance Management Company pursuant to the Management Services Agreement between the two organizations. These individuals are authorized to sign checks, enter into contracts and conduct business on behalf of Health Alliance:

John W. Pollard, MD, President
Benjamin H. Robbins, MD, Medical Director
Joseph C. Barkmeier, MD, Associate Medical Director
Kenneth G. Bash, Assistant Treasurer
Richard D. Green, Assistant Secretary
C. Carleton King, Executive Director
Jeffrey C. Ingrum, Vice-President of Finance
Martha A. Baddour, RN, Vice-President of Health Services
Judy A. Griffith, Vice-President of Operations

The need to indemnify (hold harmless) members of the HMO Advisory Board (a.k.a. Patient Satisfaction Committee) serving at the request of the corporation against threatened, pending or completed actions, suits or proceedings was discussed. It was moved, seconded and passed to amend Article VII of the by-laws to indemnify HMO Advisory Board members meeting the applicable standards of conduct in the same manner in which directors, officers, employees and agents are indemnified.

6
No. 98-1949

Supreme Court, U.S.
FILED

AUG 10 1999

OFFICE OF THE CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

REPLY BRIEF OF PETITIONERS

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Counsel for Petitioners

August 10, 1999

* *Counsel of Record*

14 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES	ii
INTRODUCTION	1
ARGUMENT	2
I. THE PANEL DECISION IS BROAD AND MAY HAVE AN ENORMOUS IMPACT ON THE DELIVERY OF HEALTH CARE	2
II. PETITIONERS DID NOT ACT AS FIDUCIARIES WHEN THEY IMPLEMENTED COST- CONTAINMENT INCENTIVES	6
III. THE QUESTION PRESENTED WAS SQUARELY DECIDED BY THE COURTS BELOW	8
CONCLUSION	10

TABLE OF AUTHORITIES

CASES

<i>Hughes Aircraft Co. v. Jacobson</i> , 119 S. Ct. 755 (1999)	8
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	8
<i>Yee v. City of Escondido</i> , 503 U.S. 519 (1992)	9

FEDERAL STATUTE

42 U.S.C. § 300e(c)	5
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REPLY BRIEF OF PETITIONERS

INTRODUCTION

In this case, the court of appeals held (1) that a health maintenance organization ("HMO") and its physicians act as fiduciaries under the Employee Retirement Income Security Act ("ERISA") when they implement a managed care program in which physicians receive financial incentives to provide medical care to HMO members in a cost-effective manner, and (2) that an allegation that an HMO and its physicians are implementing financial incentives for cost containment states a claim for breach of fiduciary duty. In opposing the petition, respondent asserts that the decision is actually narrow and therefore that neither petitioners nor their *amici* nor this Court need worry that it will cause devastating uncertainty and disruption for managed health care plans and their patients throughout the country.

Respondent chastises petitioners for misunderstanding the decision, but it is respondent who is attempting to obscure the clear holding of the court of appeals. There is no material way to distinguish the medical cost-containment incentives as analyzed by the court of appeals in this case from those in place in countless other employer-sponsored health plans.¹ There is no material way to distinguish this claim of medical malpractice from any other claims of medical malpractice involving ERISA plan participants. The panel's broad holding is that ERISA health care plans "have a fiduciary duty not to adopt HMO[s] or other managed care options," because cost-containment incentives create a conflict of interest for the health care provider. Pet. App. 54a. And the necessary effect of that

¹ See Pet. 16-17; Pet. App. 57a (Easterbrook, J., dissenting from denial of rehearing *en banc*) ("If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations.").

decision is that it is "unlawful" for an ERISA plan to adopt a health care delivery program that includes such incentives. *Id.* at 56a. See also Pet. 13-18. As a result, the panel decision is inherently in tension with Congress' express authorization of HMOs, including those which establish financial incentives for providers to contain costs, as well as the States' traditional authority to regulate the field of medical malpractice. The decision is also wrong because HMOs and physicians neither act as fiduciaries nor breach any fiduciary duty by implementing cost-containment programs that include financial incentives.

Petitioners agree with respondent on one point: This decision is the first of its kind at the court of appeals level. Its immediate, mandatory impact will thus be felt "only" in the disruption of health care delivery in Illinois, Indiana, and Wisconsin; at this point, it will only *threaten* ERISA liability for health care delivery elsewhere in the nation. Unlike respondent, however, petitioners submit that these effects demonstrate that the decision is of profound national importance and will have immediate, widespread, and damaging consequences. Certiorari is fully justified.

ARGUMENT

I. THE PANEL DECISION IS BROAD AND MAY HAVE AN ENORMOUS IMPACT ON THE DELIVERY OF HEALTH CARE.

Respondent maintains that petitioners (along with Judge Easterbrook and three other court of appeals judges) have exaggerated the breadth -- and thus the impact -- of the court of appeals' holding in a variety of ways. None of her arguments withstands scrutiny.

First, respondent relies on the panel's denial that the decision holds that financial incentives for cost containment *automatically* give rise to a breach of fiduciary duty. Opp. 4. To state a claim for fiduciary breach, the panel explains, the complaint must also allege that "the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses.)" *Id.* at 5 (quoting *Herdrich v. Pegram* 154 F.3d 362, 373 (7th Cir. 1998)). In other words, to state a claim for fiduciary breach, a plan participant or beneficiary must allege (1) that the plan has implemented financial incentives for physicians or other providers to contain costs, and (2) that the incentives affected a treatment decision. This explanation emphatically *demonstrates* petitioners' point. Almost any time a physician or other provider of health care under a health plan with financial incentives for cost containment makes a treatment decision that might have been affected by those incentives, he or she will be subject to a claim for breach of fiduciary duty. Any plaintiff's attorney can allege improper purpose on that basis. Far from narrowing its decision, the panel's explanation reveals its dramatic scope.

Respondent next argues that the panel decision is limited to the particular corporate structure of the petitioners here. She points out that the physicians of Carle Clinic "employ themselves" and "control the claims processing and utilization review" of the plan and that these physicians also receive a "year-end distribution" based on the profits achieved by their own efforts at cost containment. Opp. 7-8. Respondent never explains, however, why the panel opinion is limited to managed care organizations with this particular corporate structure. Indeed, the opinion itself contains no such statement and allows no such implication. For the panel, the critical point was that

the treating physicians had a financial incentive to contain costs and that this incentive allegedly affected their treatment decisions. This situation exists in any plan where physicians have a financial incentive to contain costs.

Respondent also correctly and irrelevantly points out that there are many different types of managed care programs; that HMOs use a "wide variety of incentive plans"; and that petitioners' plan embodies only one type of incentive program. Opp. 15-16. Distinctions among types of incentive programs were not, however, critical to the panel. It focused only on the existence of financial incentives that might affect treatment decisions. The crucial point is that most health plans employ *some* kind of financial incentives for physicians to contain costs and that, under the panel opinion, every time a physician or other provider under such a plan makes a treatment decision that allegedly was affected by the incentives, he or she (and the health plan) has a conflict of interest and may be sued in federal court for an ERISA violation.²

Respondent further contends that the panel decision does not equate medical malpractice with a breach of fiduciary duty. In support, she points out that the medical malpractice portion of her case is not even before this Court, having already been adjudicated. But respondent is again validating petitioners' point. The same facts which constitute a state-law medical malpractice claim also give rise to a federal claim under ERISA simply because the physician's judgment was made in the context of a managed care plan which includes financial

² Respondent essentially admits that most HMOs include some kind of financial incentives for physicians to contain costs, *see* Opp. 15-16. The lone counter-example of Kaiser-Permanente hardly diminishes the need for review of the decision.

incentives for cost containment.³ In other words, as petitioners' *amici* explain at greater length, the panel decision makes every treatment decision by a physician or other provider under an ERISA plan a fiduciary judgment, subject to ERISA's standards for fiduciary breach. The panel decision has thus ensured that numerous medical malpractice cases arising under state law will be filed as ERISA cases and thus will be litigated in federal court.⁴

Finally, respondent contends that the panel decision does not *inevitably* conflict with Congress' authorization of HMOs, including its express statement that HMOs may implement financial incentives for cost containment, *see* 42 U.S.C. § 300e(c). Opp. 18. It is, she asserts, still possible for an HMO to provide financial incentives for cost-containment without running afoul of ERISA. Petitioners' point, however, is not that the panel decision makes it legally impossible to implement any financial incentive for cost containment. Rather, the panel

³ Respondent belittles petitioners' reference to the American Medical Association's ("AMA's") *Principles of Medical Ethics* (1994), asserting that it does not adequately protect patients from ethical breaches that also violate the law. Opp. 6. Of course, respondent ignores petitioners' real argument -- that petitioners' conduct did not violate ERISA and that there is no policy basis to stretch ERISA beyond its logical reach because state malpractice law and the AMA ethical code in combination protect patients from physician misjudgments potentially resulting from cost-containment incentives.

⁴ Respondent also seems to argue that petitioners cannot claim the panel decision blurs the line between medical malpractice and breach of fiduciary duty claims, because petitioners opposed amendment of respondent's complaint to add the ERISA claim on the ground that it was not sufficiently related to the original medical malpractice claim. Opp. 17. The argument does not follow. There is no inconsistency in contending that a fiduciary breach is insufficiently related to a medical malpractice claim to allow amendment of a complaint alleging malpractice, while at the same time arguing that a malpractice claim does not allege a fiduciary breach simply because it also alleges that the malpractice was committed by a physician in a managed care plan.

decision strongly discourages such programs because any ERISA plan participant or beneficiary unhappy with a treatment decision may now file a federal lawsuit alleging that the decision was motivated by a financial incentive, rather than the patient's best interests, and thus was a violation of the fiduciary obligations imposed by ERISA. If the mechanism creates a conflict of interest in a fiduciary, it may be enjoined and the plan required to pay attorneys' fees. The panel decision is thus clearly in substantial tension with an important congressional policy choice as a result of its incorrect interpretation of ERISA. This policy is embodied not only in the HMO Act, but also in the Medicare and Medicaid Acts, which also authorize the use of financial incentives to promote cost containment by health care providers. See Pet. 15.

II. PETITIONERS DID NOT ACT AS FIDUCIARIES WHEN THEY IMPLEMENTED COST-CONTAINMENT INCENTIVES.

Under ERISA, a person is a fiduciary only "to the extent" that he or she is engaged in one of the activities that ERISA defines as fiduciary. Pet. 19. When that person is engaged in other activities that involve the exercise of discretion, he or she is not acting as a fiduciary even though that exercise of discretion may substantially affect the plan. *Id.* Put differently, ERISA allows persons who are fiduciaries to have dual loyalties. Petitioners in this case are ERISA fiduciaries for some purposes, but they did not act as fiduciaries when they established and implemented the cost-containment incentives in the plan at issue.

Respondent thus entirely misses the point when she argues that petitioners must be fiduciaries because they argued below that they are fiduciaries for a particular purpose. Specifically, respondent points out that when she amended her

complaint for the first time, she added the original Count III, in which she asserted that Carle Clinic *failed to disclose* certain material facts regarding the ownership of Health Alliance in violation of the Illinois Consumer Fraud Act. See Pet. App. 76a. In response, petitioners argued that they were ERISA fiduciaries *for this purpose* (i.e., the disclosure of information to plan participants and beneficiaries); that ERISA contained detailed disclosure requirements; and that the state-law disclosure claim was preempted by ERISA. The lower court agreed. See *id.* at 76a-79a. Petitioners freely acknowledge that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, e.g., when they provide information to participants as required under ERISA and when they make decisions about who is eligible for plan benefits. But petitioners' every decision is not fiduciary in nature. See Pet. 20-22. And petitioners' contention in the district court that they acted as plan fiduciaries for certain purposes does not mean that they are "arguing with themselves" when they assert in this Court that they are not acting as plan fiduciaries when they implement cost-containment incentives. Opp. 6.⁵

The panel made the same error that respondent makes. It stated that "tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility . . . in favor of 'loyalty' to his own financial interests." Opp. 5 (quoting *Herdreich v. Pegram* 154 F.3d 362, 373 (7th Cir. 1998)). A fiduciary has not jettisoned his

⁵ Respondent demonstrates that two district courts have decided that HMOs are fiduciaries when they make discretionary decisions related to plan assets, as if that were dispositive of the question here. See Opp. 20-21. But petitioners concede that many HMOs, including Carle Clinic, are fiduciaries for certain purposes. Neither of the cases cited addresses the question presented here, which is whether a managed care plan is acting as a fiduciary when it implements financial incentives for cost containment.

responsibilities when he is "loya[l] to his own financial interests" while making *non-fiduciary* decisions. Pet. App. 22a. See Pet. 20-25. ERISA's tolerance of dual loyalties plainly extends to such situations. See, e.g., *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 762-63 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890-91 (1996).⁶

III. THE QUESTION PRESENTED WAS SQUARELY DECIDED BY THE COURTS BELOW.

Respondent argues that this Court should not grant the petition because petitioners did not "[p]reserve [t]heir [a]rguments" in the courts below. Opp. 13. This argument is frivolous.

First, even a cursory review of the panel decision and the dissent from denial of rehearing *en banc* reveals that the parties addressed and the court thoroughly analyzed and decided the question presented. See, e.g., Pet. App. 10a ("defendants next contend that Herdrich has failed to state a cause of action for breach of a fiduciary duty under ERISA"). In lengthy opinions, the panel concluded that the complaint adequately pled that petitioners were ERISA fiduciaries who had breached their duty under that Act, *id.* at 11a-37a, and the panel dissent and the dissent from denial of rehearing disagreed with the panel on both points, *id.* at 39a-44a, 52a-58a.

⁶ Respondent seems to distinguish *Hughes Aircraft* and *Lockheed Corp.* on the ground that the former involved a pension plan and that both involved a plan sponsor. Neither distinction is relevant to petitioners' point. These cases stand for the proposition that an ERISA fiduciary is not a fiduciary for all purposes, so that the fact that petitioners may "have declared themselves to be ERISA fiduciaries" in one context is not dispositive in other contexts, no matter how many times respondent says so. Opp. 20.

Respondent finds it significant that in the court of appeals, petitioners made the alternative argument that there was no final judgment for the court of appeals to review. The court of appeals rejected this argument and petitioners did not seek review of that holding. We are aware of no authority that an appellant who makes an alternative jurisdictional argument fails to preserve all of the other arguments it actually presented below.

Next respondent argues that "[a]t no point during the initial appeal did petitioners argue 42 U.S.C. § 300(e) or 42 C.F.R. § 417.479." Opp. 13. Respondent conveniently ignores that both of these provisions are mentioned in opinions in the court of appeals, see Pet. App. 44a, 58a, and concedes that both were cited in the petitions for rehearing, Opp. 14. In any event, petitioners are citing these provisions only as further support for arguments already made. Once a federal issue is properly raised, a party can make any argument in support of its position on that issue. "[P]arties are not limited to the precise arguments they made below." *Yee v. City of Escondido*, 503 U.S. 519, 534 (1992) (citing, *inter alia*, *Bankers Life & Cas. Co. v. Crenshaw*, 486 U.S. 71, 78 n.2 (1988)); *id.* at 535 ("[h]aving raised a . . . claim in the [lower] courts, . . . petitioners could have formulated any argument they liked in support of that claim here").

Finally, respondent claims that the procedural posture of the case, which was dismissed at the pleading stage, makes certiorari review inappropriate. She asserts that it is unclear whether the plan was self-insured or insured, which HMO model Carle Clinic embodied, and whether the Carle Clinic was federally qualified. Opp. 14-15. But none of these facts is material to the question presented, because none would alter the panel decision that when an ERISA plan makes a decision that is merely alleged to have been motivated by financial incentives

for cost containment, it breaches its fiduciary duty to its participants and beneficiaries. Indeed, the procedural posture of the case serves starkly to illuminate the purely legal question presented: Whether HMOs and physicians are acting as fiduciaries and breach their fiduciary duty under ERISA when they implement financial incentives for cost containment.

* * * *

The petition shows that the court of appeals has issued an incorrect decision that is in tension with congressional policy and decisions of this Court. Its consequences are damaging and disruptive to numerous health care providers under ERISA plans. As Judge Easterbrook explained, if the decision stands, then "the principal organizational forms through which medical care is delivered today are unlawful" when employed by an ERISA plan. Pet. App. 56a (Easterbrook, J., dissenting from denial of rehearing *en banc*). These consequences are engendered by a substantial and unwarranted expansion of the scope of fiduciary liability under ERISA. The substantial effects of this erroneous decision on one of the most important sectors of the national economy make this case worthy of the Court's full review.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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August 10, 1999

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MOTION FILED
JUL 28 1999

No. 98-1949

IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

**On Petition for Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit**

**MOTION FOR LEAVE TO FILE BRIEF AND
BRIEF OF WASHINGTON LEGAL FOUNDATION
AS AMICUS CURIAE IN SUPPORT OF PETITIONERS**

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Date: July 28, 1999

2088

**IN THE
SUPREME COURT OF THE UNITED STATES**

No. 98-1949

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
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v.

CYNTHIA HERDRICH,
Respondent.

**On Petition for Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit**

**MOTION FOR LEAVE TO FILE BRIEF
OF WASHINGTON LEGAL FOUNDATION AS
AMICUS CURIAE IN SUPPORT OF PETITIONERS**

Pursuant to Rule 37.2 of the Rules of this Court, the Washington Legal Foundation respectfully moves for leave to file the attached brief as *amicus curiae* in support of Petitioners. Petitioners have consented to the filing of this brief; their letter of consent has been lodged with the Clerk of the Court. Respondent has declined to consent, thereby necessitating the filing of this motion.

The Washington Legal Foundation (WLF) is a non-profit public interest law and policy center with supporters nationwide, including many in Illinois. While WLF engages in litigation and participates in administrative

proceedings in a variety of areas, WLF devotes a substantial portion of its resources to advancing the interests of the free-enterprise system and to ensuring that economic development is not impeded by excessive litigation. To that end, WLF has appeared before this Court as well as other federal and state courts in cases raising tort liability issues arising under the Employee Retirement Income Security Act of 1974 (ERISA). See, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). WLF also has appeared in cases touching upon the effects of tort liability on the ability of health care providers to deliver quality service to the American public. See, e.g., *Rotella v. Wood*, No. 98-896 (decision pending, U.S. S.Ct.); *Medtronic, Inc. v. Lohr*, 116 S. Ct. 2240 (1996).

WLF is concerned by the proliferation of suits against health maintenance organizations (HMOs) and their fiduciaries being brought pursuant to ERISA. WLF believes that such suits have the potential -- particularly when, as here, they are directed at physicians' individual treatment decisions -- to cause serious disruption to the delivery of quality, affordable health care.

WLF fully agrees with Petitioners both that the appeals court's decision misinterpreted ERISA and that -- by extending ERISA fiduciary responsibilities to encompass cost-containment mechanisms -- it will undermine efforts to ensure that quality health care is widely available at affordable costs. WLF is filing separately in order to emphasize the pernicious effects of one aspect of the appeals court decision: the holding that *physicians'* treatment decisions are also subject to ERISA standards. That holding will directly undermine medical care; by decreeing that treating physicians owe a fiduciary duty to the plan *as a whole*, the holding diverts physicians from their state-law

responsibility to focus on the treatment needs of individual patients.

WLF is filing this brief because of its interest in maintaining high-quality health care to all Americans. It has no interest in the outcome of this lawsuit or of any other suits raising similar issues. Because of its lack of direct economic interests, WLF believes that it can assist the Court by providing a perspective that is distinct from that of any party.

For the foregoing reasons, WLF respectfully requests that it be allowed to participate in this case by filing the attached brief.

Respectfully submitted,

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Date: July 28, 1999

QUESTION PRESENTED

Whether a health maintenance organization (HMO) and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1104(a)(1), by implementing a managed care program in which the physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF CONTENTS	ii
TABLE OF AUTHORITIES	iii
INTEREST OF <i>AMICUS CURIAE</i>	1
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE PETITION	3
I. THE MISAPPLICATION OF ERISA TO PHYSICIANS' TREATMENT DECISIONS WILL UNDERMINE THE PROVISION OF QUALITY HEALTH CARE UNDER ERISA PLANS	5
II. THE COURT OF APPEALS' DECISION COULD IMPROPERLY SUBJECT OTHER TYPES OF PROFESSIONAL SERVICES TO ERISA'S FIDUCIARY STANDARDS, UNDERMINING THE QUALITY OF NON-MEDICAL PROFESSIONAL SERVICES PROVIDED UNDER ERISA PLANS	10
CONCLUSION	13

TABLE OF AUTHORITIES

	Page
Cases:	
<i>Addison v. Whittenberg</i> , 529 N.E.2d 552 (Ill. 1988)	7
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<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	6
Statutes:	
Employee Retirement Income Security Act of 1974 ("ERISA")	<i>passim</i>
ERISA § 3(1)	10, 11
ERISA § 3(21)(A)	6
ERISA § 404(a)(1)(A), (B), (D)	6
Other Materials:	
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	Page
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**IN THE
SUPREME COURT OF THE UNITED STATES**

No. 98-1949

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

**On Petition for Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit**

**BRIEF OF WASHINGTON LEGAL FOUNDATION AS
AMICUS CURIAE IN SUPPORT OF PETITIONERS**

INTEREST OF THE AMICI CURIAE

The interest of *amicus curiae* Washington Legal Foundation is set forth in the motion accompanying this brief.¹

¹ Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amicus*, contributed monetarily to the preparation and submission of this brief.

STATEMENT OF THE CASE

The *amicus* incorporates the Statement of the Case in the Petition for Writ of Certiorari and briefly summarizes the identities of the parties and the decision of the United States Court of Appeals for the Seventh Circuit.

Respondent Cynthia Herdrich received medical treatment through an HMO. Petitioners are the physician (Dr. Pegram) who provided treatment to Ms. Herdrich, the operator of the HMO (Health Alliance Medical Plans, Inc. or "HAMP"), and HAMP's owner (Carle Clinic Association or "Carle Clinic").

The physicians who provide services to patients covered by the HMO own Carle Clinic, which is the sole shareholder of HAMP. HAMP received a fixed amount per patient to provide services to HMO patients. Thus, the less money expended on patient care, the better HAMP's short-term financial return. In turn, the more money that HAMP and the Carle Clinic made, the larger the financial reward to the physicians who provided services to HMO patients. This compensation scheme can be viewed as providing either of two incentives. It may encourage physicians to provide diagnosis and treatment at the earliest possible stage in the hope of keeping long-term costs down and profits up, or it may encourage physicians to skimp on current treatment in the hope of driving short-term profits up. The Court of Appeals, reviewing a ruling on a motion to dismiss the complaint, accepted the Respondent's allegation that the second incentive governed the medical judgment at issue.

This case arose because Dr. Pegram misjudged the urgency of Ms. Herdrich's need for medical treatment.

Instead of sending Ms. Herdrich to the emergency room for an immediate sonogram to determine whether an appendectomy was required, Dr. Pegram chose a cheaper option, scheduling the sonogram for a later date at a different facility. Choosing the cheaper option reduced the short-term cost of providing care to Ms. Herdrich, thereby enhancing the financial return to HAMP and Dr. Pegram.²

The Court of Appeals concluded that the Carle Clinic and HAMP were fiduciaries under ERISA because they had the right to decide disputed claims of individuals covered by the HMO. *Herdrich v. Pegram*, Pet. App. 14a. Dr. Pegram was a fiduciary because she exercised discretion in rendering care to individuals covered by the HMO. *Id.* at 19a. The Court of Appeals further found that the financial incentives under which Dr. Pegram operated as a fiduciary could give rise to a fiduciary breach where, as alleged by the Respondent, a physician delays or withholds care to benefit herself financially. *Id.* at 20a.

REASONS FOR GRANTING THE PETITION

Amicus fully supports the Petitioners' reasons for granting the petition. The Court of Appeals' decision could severely disrupt the ability of employer-sponsored plans to deliver care in a cost-effective manner, interfering

² In retrospect, of course, it would have been far cheaper for all of the Petitioners if Dr. Pegram had chosen the more expensive emergency room option, thereby avoiding the cost of treating Ms. Herdrich's peritonitis. Similarly, the sensible response of employers whose employees receive the type of treatment that Ms. Herdrich received is to change HMOs. Thus, while discounted by the Court of Appeals, market forces should keep HMOs from skimping on care for short-term gains.

with the operation of a significant segment of the economy and the health care coverage of a large percentage of the population.

In 1997, the last year for which data are available from the Health Care Financing Administration, Americans spent \$1.1 trillion on health care or 13.5% of the gross domestic product, and experts predict national health spending will rise to \$2.1 trillion by the year 2007. Sheila Smith et al., *The Next Ten Years of Health Spending: What Does the Future Hold*, Health Affairs, Sept./Oct. 1998, at 128-29. Nearly two-thirds of health insurance coverage is provided through employer-sponsored plans. Employee Benefit Research Institute, *EBRI Databook on Employee Benefits* 211 (4th ed. 1997).

The Court of Appeals' decision not only threatens the operation of these health plans, it also could interfere with the delivery of services at the patient level. This is because the Court of Appeals reached the remarkable conclusion that a physician may become a fiduciary under ERISA by exercising discretion in providing patient care. This, in turn, would subject the physician's individual treatment decisions to ERISA's fiduciary standards -- standards wholly unsuited to regulate patient care.

The purpose of health plans is to provide a means of paying for the treatment provided by physicians, nurses, and other health care professionals. The plans that serve as this payment mechanism are subject to ERISA, which requires that the persons responsible for the administration of a plan act prudently in the management of the plan's assets and the conduct of the plan's business under a framework of rules largely drawn from private trust law.

The Court of Appeals, intent on eliminating financial incentives it viewed as inconsistent with good patient care, decided to superimpose ERISA's rules designed to govern the relationship between trustee and beneficiary to a wholly different relationship, that of doctor and patient. By doing so, the Court of Appeals has applied a legal regimen designed to regulate the investment of trust assets to a physician's treatment decisions made in the ordinary course of patient care. It is difficult to imagine a more unsuitable application of rules designed to govern one set of behaviors to conduct of a wholly different character and purpose. By confusing paying for treatment with the treatment itself, the Court of Appeals has created a legal quagmire that will substantially upset the operation of the nation's health care system and subvert the standard of care that physicians owe to their patients.

The Court of Appeals' decision impacts nearly 10% of the economic activity of this country by imposing on the practice of medicine a regulatory regime that was never designed for, and is plainly not suited to, that purpose. Moreover, the imposition of fiduciary status and resulting regulation under ERISA could spill over to lawyers, teachers, and others who provide professional services paid for through ERISA plans. The Court should grant review of the decision to prevent such a misguided and dangerous outcome.

I. THE MISAPPLICATION OF ERISA TO PHYSICIANS' TREATMENT DECISIONS WILL UNDERMINE THE PROVISION OF QUALITY HEALTH CARE UNDER ERISA PLANS.

A person is a fiduciary under ERISA to the extent the person exercises any discretionary authority or discre-

tionary control respecting management of the plan or exercises any authority or control respecting management or disposition of the plan's assets or has any discretionary authority or discretionary responsibility in the administration of the plan. ERISA § 3(21)(A).

Those who fall under the definition of ERISA fiduciary must carry out their duties with respect to a benefit plan solely in the interest of the plan's participants and beneficiaries, for the exclusive purpose of providing benefits and defraying reasonable administrative costs, in a prudent manner and in accordance with the documents and instruments governing the plan. ERISA § 404(a)(1)(A), (B), (D); 29 U.S.C. § 1104(a)(1)(A), (B), (D). To meet these duties, fiduciaries must consider the interests of the participants and beneficiaries of the benefit plan as a whole, not the interests of any one participant. *See Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996) ("a fiduciary obligation...does not necessarily favor payment over nonpayment. The common law of trusts recognizes the need to preserve assets to satisfy future as well as present claims and requires a trustee to take impartial account of the interests of all beneficiaries."). For this reason, an ERISA fiduciary does not breach his or her fiduciary duty by denying a benefit claim for services that are not covered under the benefit plan, even though the services may be appropriate as a matter of medical judgment. *E.g., Martin v. Blue Cross and Blue Shield of Virginia*, 115 F.3d 1201, 1209 (4th Cir.), *cert. denied*, 522 U.S. 1029 (1997) (health plan participant not entitled to payment for treatment recommended by her physician but not covered under health plan).

In contrast to ERISA fiduciaries, physicians, by virtue of state law, are held to a standard of care to the individual

patient. A physician is required to recommend appropriate treatment based on the patient's interest. *See, e.g., Addison v. Whittenberg*, 529 N.E.2d 552, 556 (Ill. 1988). Thus, subjecting physicians' treatment decisions to ERISA standards, which are designed to ensure plan integrity, will not enhance medical care. At best, applying ERISA standards to physicians will add an unnecessary layer of regulation and at worst could undermine physicians' ability to provide quality care to their patients.

The Court of Appeals' decision permits this perverse result. As described in the decision, a physician's exercise of discretion in prescribing a particular course of treatment may make the physician a fiduciary under ERISA. *Herdrich v. Pegram*, Pet. App. 19a, 20a. If the physician's compensation through an ERISA-covered plan is affected by the care he or she prescribes, ERISA would require the physician, as a fiduciary of the plan, to temper his or her decisions regarding the appropriate treatment for individual patients by taking account of the financial impact a particular treatment recommendation may have on the plan as a whole and on the plan's participants as a group. Thus, a physician burdened with the mantle of ERISA fiduciary could rightly decide under ERISA to withhold expensive treatment from a near-terminal patient in order to conserve scarce resources for the benefit of the healthier majority of plan participants. These non-medical, financial considerations are the very essence of what the Court of Appeals thought should *not* influence physicians at the treatment level. *Id.* at 31a ("doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients.").

Moreover, the effect of the Court of Appeals' decision is not limited to doctor-owned HMOs, like the one the

Court of Appeals considered. The exercise of medical judgments almost always has direct or indirect financial consequences to the treating physician. Under traditional fee-for-service arrangements, for example, doctors exercise discretion in making treatment decisions. Virtually all of these treatment decisions have financial ramifications because the doctor determines the treatment that he or she will perform and be paid for. See Lee Holleman et al., *Are Ethics and Managed Care Strange Bedfellows or a Marriage Made in Heaven?*, 349 *Lancet* 350 (1997) ("In the fee-for-service system, however, physicians had an intrinsic incentive to overtreat, which contributed to the high incomes of doctors and the high cost of health care but not necessarily to better outcomes.").

In addition to affecting their direct compensation through their treatment decisions, doctors also can affect their compensation by prescribing diagnostic tests to be performed by laboratories in which they own an interest. Bruce J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice - A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 *New Eng. J. Med.* 1604 (1990). Unlike the incentives imposed by managed care, these types of incentives may lead to excessive testing and procedures, which can be equally as harmful to a patient as withholding treatment. Peter Franks et al., *Gatekeeping Revisited - Protecting Patients from Overtreatment*, 327 *New Eng. J. Med.* 424 (1992). The financial incentive to provide unnecessary services reduces the quality of care by subjecting participants to excessive

testing and procedures.³ If, as the Court of Appeals determined, the existence of financial incentives that could adversely influence a physician's medical judgment gives rise to a fiduciary breach, then even traditional fee-for-service arrangements, when funded through an ERISA-covered plan, could give rise to a fiduciary breach.

³ Numerous studies have consistently found that capitation-fee arrangements incur lower costs than fee-for-service arrangements with quality equal to or better than fee-for-service care. See Peter Franks et al., *Gatekeeping Revisited - Protecting Patients from Overtreatment*, 327 *New Eng. J. Med.* 424 ("Several authors have expressed concern that primary care physicians whose income is directly linked to the extent to which they limit the use of resources may undertreat patients. Although this market view of physicians' behavior is plausible, there is little empirical evidence that primary care physicians withhold beneficial care for financial reasons," and the Rand Health Insurance Experiment revealed that inappropriate surgery was selectively reduced in capitation arrangements.); Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 *New Eng. J. Med.* 1227 (1996) ("If anything, the data suggest hazards and ethical problems in the overuse of services in fee-for-service settings, rather than its underuse in capitated care."); David A. Durfee, *Capitated Care is Ethical*, *Archives of Ophthalmology* (Sept. 1997) ("To suggest that a particular physician functions ethically under a fee-for-service system but not under capitation is inaccurate. The reality is 'good' physicians function well in either environment; 'bad' physicians do poorly under both systems of reimbursement."); see also R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Health Care*, 76 *Milbank Q.* 649 (1998).

II. THE COURT OF APPEALS' DECISION COULD IMPROPERLY SUBJECT OTHER TYPES OF PROFESSIONALS TO ERISA'S FIDUCIARY STANDARDS, UNDERMINING THE QUALITY OF PROFESSIONAL SERVICES PROVIDED UNDER ERISA PLANS.

Professional services other than medical care are funded through ERISA plans, and the Court of Appeals' decision could turn professionals exercising discretion in providing services to individuals covered by these plans into ERISA fiduciaries, also. This, in turn, would subject the professionals' conduct to ERISA's fiduciary standards. Just as ERISA's fiduciary standards are the wrong measure for judging medical care, ERISA's fiduciary standards similarly do not provide an appropriate measure for judging the services provided by lawyers, counselors, teachers, and other professionals whose services are paid for through employee benefit plans. More significantly, using ERISA standards to judge these professional services could interfere with the exercise of professional judgment in individual cases, reducing the quality of professional services that participants receive under ERISA plans.

Pre-paid legal services, for example, may be funded through ERISA plans. ERISA § 3(1); 29 U.S.C. § 1002(1). The services are provided pursuant to contracts with law firms or particular attorneys, usually based on a flat fee per participant or per type of project. Because these arrangements do not compensate attorneys based on the time they spend on a project, attorneys have a financial incentive to spend as little time on a project as possible. Attorneys in this situation exercise the same type of discretion as Dr. Pegram in deciding what course of action to recommend to a client. Under the Court of Appeals'

reasoning, this would make them fiduciaries of the legal services plan. And like Dr. Pegram, lawyers providing services to plan participants would in many cases own their firm or stock in the professional corporation, giving them an incentive to withhold services to enhance their financial return.

Codes of conduct and malpractice standards that apply to attorneys require them to consider the interests of clients, not their own financial interests, in providing legal advice. If an attorney or firm gives a participant bad legal advice, the participant's recourse against the attorney or firm is a malpractice action under state law. The Court of Appeals' decision, however, would give the participant a claim for breach of fiduciary duty under ERISA.

Under the Court of Appeals' reasoning, an attorney who provides legal advice under an arrangement that creates a financial incentive to skimp on services or otherwise fail to provide the highest quality services could be deemed to have breached fiduciary duties. This, in turn, would subject the attorney's *legal judgments* to ERISA's fiduciary requirements. ERISA's standards, however, with their emphasis on ensuring plans' financial integrity, are no better suited to regulate legal services than medical care.

Other types of professional services funded through ERISA plans include counseling services under employee assistance programs, on-site day care, outplacement services, and apprenticeship training. ERISA § 3(1); Department of Labor Advisory Opinion ("DOL Adv. Op.") 83-35A (June 27, 1983); DOL Adv. Op. 91-26A (June 9, 1991); DOL Adv. Op. 97-12A (April 18, 1992). Counselors, social workers, and teachers providing services

under these plans exercise discretion in providing services to individual plan participants, which, under the Court of Appeals' decision, could make these professionals plan fiduciaries. To the extent the plans' contractual arrangements with professionals create financial incentives that could influence the professionals' judgment in providing services, then the advice provided by the professionals could give rise to a fiduciary breach.

ERISA's standards, however, simply do not provide an adequate substitute for, much less an improvement over, the legal and ethical constraints that already regulate professionals such as physicians, attorneys, counselors, and teachers under state law. The fact that services performed by these professionals are paid for through the mechanism of an employee benefit plan subject to ERISA should not change the standards that apply to their exercise of professional judgment. Changing the standard would have the perverse result of lowering the quality of care provided under ERISA-covered plans, especially health plans.

Left unchanged, the Court of Appeals' decision threatens the operation of the country's health care system both at the plan level, as described by the Petitioners, and at the individual patient level. To avoid these misguided effects, the Court should review the decision.

CONCLUSION

Amicus curiae Washington Legal Foundation respectfully requests the Court to grant the Petition.

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LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION and
HEALTH ALLIANCE MEDICAL PLANS, INCORPORATED

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

**MOTION OF THE AMERICAN ASSOCIATION OF
HEALTH PLANS, THE HEALTH INSURANCE
ASSOCIATION OF AMERICA, THE ASSOCIATION OF
PRIVATE PENSION AND WELFARE PLANS, AND THE
CHAMBER OF COMMERCE OF THE UNITED STATES
FOR LEAVE TO FILE BRIEF *AMICI CURIAE* IN SUPPORT
OF PETITIONERS AND BRIEF *AMICI CURIAE***

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Pursuant to Rule 33.1 of the Rules of the Supreme Court, Amici, the American Association of Health Plans ("AAHP"), the Health Insurance Association of America ("HIAA"), the Association of Private Pension and Welfare Plans ("APPWP"), and the Chamber of Commerce of the United States (the "Chamber") hereby move for leave to file the attached brief Amici Curiae.

Counsel for Petitioners-Appellants, Virginia Seitz, Esq. of the law firm of Sidley & Austin, 1722 Eye Street, N.W., Washington, D.C. 20006, has given permission for Amici to file a supporting brief. Counsel for Respondent-Appellee, James Ginzkey, Esq. of the law firm of Hayes, Miles, Cox and Ginzkey, 202 North Center Street, P.O. Box 3067, Bloomington, Illinois 61702-3067, has refused to give permission for Amici to file such a brief. The reasons for filing of this Amicus Brief are succinctly set forth below.

AAHP is a national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 health plans serving nearly 140 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* ("ERISA").

HIAA is a national association for private health insurance companies and is an advocate for the private, market-based health insurance system. Its more than 225 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to 110 million Americans.

The APPWP is a broad based, non-profit trade association founded to protect and foster the growth of this Nation's privately sponsored employee benefit plans. The members of APPWP include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers, and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants.

The Chamber is the world's largest business federation representing an underlying membership of more than three million businesses and organizations of every size, in every sector and region. One of the Chamber's functions is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the business community. The ability of its member organizations to both provide and purchase affordable, quality healthcare is of tremendous importance to the Chamber's member organizations.

As representatives of the health plan, health insurance, and business community, AAHP, HIAA, APPWP, and the Chamber have a strong interest in the federal questions presented by this case under ERISA. The member organizations of AAHP, HIAA, APPWP, and the Chamber provide health benefits to employees and arrange for the provision of health care services to employee benefit plans regulated under ERISA. Further, many of the Chamber's and APPWP's member organizations are purchasers of health care services.

The Seventh Circuit's holding that benefit design features (here, an HMO's use of legal cost-containment measures), can violate the fiduciary duty provisions of ERISA will have a dramatic effect on the ability of the employee benefit plan community and the health care industry to control costs while providing quality care. Creating ERISA liability for common plan design features will drive up the cost of health care coverage and will discourage employers from purchasing managed care services or insurance products, or from otherwise providing health care coverage to their employees.

AAHP, HIAA, APPWP, and the Chamber believe that they can show this Court that the Seventh Circuit's decision will have a substantial negative impact on the way their member organizations administer and structure the delivery of health care services to employee benefit plans, to the detriment of affordable, quality health care.

WHEREFORE, AAHP, HIAA, APPWP, and the Chamber respectfully request leave to file the accompanying brief as Amici Curiae.

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TABLE OF CONTENTS

	<i>Page</i>
Table of Cited Authorities	ii
Table of Appendices	vii
Statement of Interest	1
Summary of Argument in Support of Appellants' Petition for Writ of Certiorari.	3
Argument	4
A. Introduction	4
B. The Court of Appeals' Holding Imposes Unnecessary Burdens on Employee Benefit Plans	7
C. Financial Incentive Arrangements in Managed Care Are Beneficial to Both Patients and Physicians	10
D. The Decision Below Contravenes Uniform Federal and State Policy Permitting Cost Containment Measures in Health Plans	13
E. ERISA Does Not, and Should Not, Provide an Alternate Remedy for Medical Malpractice	18
Conclusion	20

TABLE OF CITED AUTHORITIES

	<i>Page</i>
Cases:	
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<i>United States v. Ruzicka</i> , 329 U.S. 287 (1946)	4
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	19
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29 U.S.C. § 1109	19

<i>Cited Authorities</i>	<i>Page</i>
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29 U.S.C. § 1133	15
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42 U.S.C. § 300(e)(c)(2)(D)	14
42 U.S.C. § 300gg	16
42 U.S.C. § 300gg-41	16
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FLA. STAT. ANN. § 627.4234	15
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	Page
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	Page
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	<i>Page</i>
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57 FED. REG. 59,024	15
42 C.F.R. § 417.479	15

TABLE OF APPENDICES

	<i>Page</i>
Appendix — Compilation Of Relevant Studies And Articles	1a

STATEMENT OF INTEREST

The American Association of Health Plans ("AAHP") is a national association for the managed health care community.¹ Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 health plans serving nearly 140 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

The Health Insurance Association of America ("HIAA") is a national association for private health insurance companies and an advocate for the private, market-based health insurance system. Its more than 225 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to 110 million Americans.

The Association of Private Pension and Welfare Plans ("APPWP") is a broad based, non-profit trade association founded to protect and foster the growth of this Nation's privately sponsored employee benefit plans. The members of APPWP include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms,

1. Counsel for the Amici were the sole authors of this brief. No person or entity other than Amici made a financial contribution to this brief.

investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans which cover more than 100 million plan participants.

The Chamber of Commerce of the United States (the "Chamber") is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations of every size, in every sector and region. One of the Chamber's functions is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the business community. The ability of its member organizations to both provide and purchase affordable, quality healthcare is of vital importance to the Chamber's member organizations.

As representatives of the health plan, health insurance and business community, AAHP, HIAA, APPWP, and the Chamber have a strong interest in the federal questions presented by this case under ERISA. The member organizations of Amici provide health benefits to employees or arrange for the provision of health care services to employee welfare benefit plans regulated under ERISA. Further, many of the APPWP's and the Chamber's member businesses are purchasers of health care services.

Amici have joined together to file this brief in support of the Petition for Certiorari because of the court of appeals' novel interpretation of ERISA and that statute's established body of caselaw, as well as the extraordinary significance that the holding will have on sponsors of employee welfare benefit plans and health insurance issuers. Counsel for Appellants, Virginia Seitz, Esq., of the law firm of Sidley &

Austin, has given her consent for Amici to file this brief. Counsel for Appellee, James Ginzkey, Esq., of the law firm of Hayes, Miles, Cox and Ginzkey, has refused to give permission for Amici to file this brief.

The Seventh Circuit's holding that health plan benefit design features, such as an HMO's use of legal cost-containment measures, can violate the fiduciary duty provisions of ERISA, will have a dramatic effect on the ability of the employee benefit plan community and the health care industry to control costs while providing quality care. Creating ERISA liability for common plan design features will drive up the cost of health care coverage and will discourage employers from purchasing managed care services or insurance products, or from otherwise providing health care coverage to their employees.

SUMMARY OF ARGUMENT IN SUPPORT OF APPELLANTS' PETITION FOR WRIT OF CERTIORARI.

The holding of the Seventh Circuit Court of Appeals threatens the ability of employers to provide comprehensive health benefits to the over 160 million Americans receiving health coverage through their employment. In essence, the lower court's holding, if it is allowed to stand, subjects normal and necessary cost containment mechanisms included in all health plans to challenge under both state tort law and ERISA, notwithstanding the fact that such cost containment measures are expressly encouraged and often are mandated by both state and federal laws and regulations.

Moreover, the lower court's holding is a novel interpretation of ERISA's fiduciary provisions that will have

far reaching negative consequences for the employer sponsored benefit plan community, the health insurance industry, and the American public. The decision below does violence to both the intent and text of ERISA because it (1) discourages employers and others from maintaining benefit plans, inevitably increasing the ranks of the uninsured, and (2) creates a new tort for "breach of fiduciary duty" that finds no basis in ERISA.² The result is an arrogation of power to the courts that Congress intended be left in private hands.

ARGUMENT

A. Introduction

In an unprecedented decision, the Seventh Circuit has transformed a garden-variety medical malpractice case into a serious threat to the cost-containment measures of health insurance issuers and of employee benefit plans, whether they are self-insured, insured through managed care organizations ("MCOs"), or sponsored by governmental entities such as Medicare. The facts, as alleged by plaintiff Cynthia Herdrich, illustrate a classic example of improper medical judgment. Lori Pegram, a physician employed by the petitioner Carle Clinic Association, examined Ms. Herdrich. Although a mass was discovered in her abdomen, an eight-day delay in providing her with a sonogram resulted in a ruptured appendix and peritonitis. In a separate action,

2. See, e.g., *American Federation of Musicians v. Wittstein*, 379 U.S. 171, 175 (1964) (certiorari appropriate where question presented is an important one of first impression under a statute); *United States v. Ruzicka*, 329 U.S. 287, 287 (1946) (certiorari appropriate where decision significantly affects the administration of a statute); *Patterson v. Lamb*, 329 U.S. 539, 541 (1947) (certiorari appropriate where many individuals are affected by decision below).

an Illinois jury awarded Ms. Herdrich damages of \$35,000 against Dr. Pegram for medical malpractice.

A divided panel of the Seventh Circuit improperly transformed that state-law based malpractice claim into a breach of fiduciary duty claim under ERISA. The majority held that the mere allegation that an HMO or its physicians implements cost-containment mechanisms that include physician inducements states a claim for breach of fiduciary duty under ERISA.

Currently, 160 million non-elderly Americans depend upon privately sponsored employer health and welfare plans subject to ERISA for their health care coverage.³ Employers, after a period of relatively stable health care costs, are once again facing health care inflation. Consequently, they are beginning to withdraw their economic support of health and welfare plans, or are limiting their contributions to fixed amounts, thus passing the inflationary burden to their employees. As a result, the number of Americans who are without health care coverage has increased, and is projected to increase further if appropriate action is not taken.⁴

This decision, if not overturned, will be devastating to current efforts by Congress, the Executive Branch, and the private sector to contain health care costs while attempting

3. See Peter T. Kilborn, *Insurers Raise Health Coverage Costs to New Highs*, THE TOPEKA CAPITAL-JOURNAL, December 20, 1998; see also STEVEN FINDLAY & JOEL MILLER, NATIONAL COALITION ON HEALTH CARE, DOWN A DANGEROUS PATH: THE EROSION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES 4 (1999) (stating that 61% of Americans receive health care coverage through their employer).

4. See FINDLAY & MILLER, *supra* note 3, at 5.

to strike the proper balance between cost control incentives and responsibility to patients. This broadside attack, unfortunately, comes at a time when the number of uninsured Americans is rising and when health care costs are continuing their ascent.

At present, 43 million Americans remain uninsured⁵ and projections are that one million additional people will become uninsured each year, despite the burgeoning growth in the United States economy.⁶ Economic and political factors have curtailed the availability of alternate governmental sources of health care coverage such as Medicaid and Aid to Families with Dependent Children.⁷ As health care costs continue to rise (they are projected to reach \$1.5 trillion annually by 2002),⁸ Congress and the state legislatures are desperately searching for alternative ways to assure coverage, and are considering measures such as additional tax credits for health insurance premiums and grants to low income families to buy insurance. The Seventh Circuit's decision is counter to that trend, as it will severely limit this country's ability to maintain, much less to expand, health care

5. See *id.* at 1; see also WILLIAM S. CUSTER, HEALTH INSURANCE ASSOCIATION OF AMERICA, HEALTH INSURANCE COVERAGE AND THE UNINSURED 3 (1999) (same).

6. See KENNETH E. THORPE, NATIONAL COALITION ON HEALTH CARE, THE RISING NUMBER OF UNINSURED WORKERS: AN APPROACHING CRISIS IN HEALTH CARE FINANCING 1 (1997); see also CUSTER, *supra* note 4, at 5 (estimating that approximately fifty-three million Americans will be uninsured by 2007).

7. See FINDLAY & MILLER, *supra* note 3, at 10.

8. See THORPE, *supra* note 6, at 2.

coverage, and to prevent a return to the health care cost hyperinflation of the 1970s and 1980s.⁹

The court of appeals' decision exacerbates the crisis by effectively exempting medical professionals alone from the necessary discipline of the marketplace. Only Judge Flaum, in dissent, recognizes the economic reality that private and public efforts to contain health care costs are necessary, and that those efforts must include all sectors of the health care industry, including medical professionals.¹⁰ The alternative is unacceptable: a return to "open checkbook" medical reimbursement. The dissent also correctly points out that both federal and state law are replete with measures allowing or even mandating cost-containment measures, and that supervision of employer-sponsored benefit plans and managed care constitutes a legislative and regulatory function that the courts are ill-equipped to perform.

B. The Court of Appeals' Holding Imposes Unnecessary Burdens on Employee Benefit Plans

The court of appeals' decision makes it impossible for anyone to design or administer benefit plans without the risk of becoming an ERISA plan fiduciary, subject to being continuously second-guessed and penalized by plaintiffs and courts. In enacting ERISA, Congress did not intend the federal courts to substitute their views of what constitutes appropriate plan design for the judgments of employers and

9. See CUSTER, *supra* note 5, at 4-5.

10. See *Herdrich v. Pegram*, ("Herdrich"), 154 F.3d 362, 380-384 (7th Cir. 1998) (Flaum, J., dissenting), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999), *petition for cert. filed*, (U.S. June 4, 1999) (No. 98-1949).

plan sponsors. The appropriate judicial inquiry is: *In administering the plan, has there been a breach of ERISA's fiduciary duties?* The duty of an ERISA fiduciary is to implement a plan in accordance with that plan's design and in accordance with that fiduciary's own best judgment.¹¹ After *Herdrich*, courts now have authority to engage in the following inquiry, sanctioned by the Seventh Circuit: *Does a court believe that a plan design might be unfair or might harm a plan member?*

Not only does the Seventh Circuit's decision arrogate to the courts the right to second-guess plan design, but it establishes an unprecedented and dangerous principle of ERISA fiduciary liability. That principle can be summarized as follows: *Any entity that administers any aspect of a deficient or unfair plan or who exercises a professional judgment which affects the provision of benefits is thereby rendered a plan fiduciary. Moreover, where the professional judgment is negligently made, that negligence will constitute a breach of fiduciary duty.*

As Judge Easterbrook remarked in his dissent from the Seventh Circuit's denial of rehearing *en banc*, the decision has far-reaching consequences:

If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of

11. Employee Retirement Income Security Act of 1974 (ERISA), § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1974).

profit from cost-reducing strategies) . . . are the principal features of HMOs and "preferred provider organizations."¹²

Those features, all designed to control the cost of providing health care benefits, have traditionally not been subject to judicial review. *Herdrich*, however, allows a plaintiff to challenge every single decision made in the context of establishing or administering a health plan, including:

- *Decisions respecting structural and administrative issues.* Routine business judgments, such as the selection of a specific health care delivery system and what form that entity will take, could now be subject to claims of fiduciary breach.
- *Decisions respecting benefit design and delivery.* All plans exclude or limit certain benefits for cost reasons, limiting benefits to "medically necessary" care or excluding coverage for cosmetic surgery. The court of appeals' opinion allows such decisions to be challenged as a "breach of fiduciary duty."
- *Decisions of physicians and other health professionals respecting the appropriate type and level of care.* Questions such as whether a person needs to be hospitalized, or whether a child needs Tylenol or a stronger drug to control pain, will all be transformed into fiduciary decisions.

12. *Herdrich v. Pegram*, 170 F.3d 683, 687 (7th Cir. 1999) (Easterbrook, J., dissenting).

It is hard to exaggerate the enormous adverse impact that the decision is likely to have on employee benefit plans and health care providers if left unreviewed. If employers, plan administrators, and health professionals are subject to liability for selection of a health care delivery system and plan design, there will be an increase in litigation. The fear of the associated liability and increase in costs will decrease the likelihood that health insurance issuers will be able to provide cost-effective, comprehensive products, and that employers will continue to provide employees with health care coverage.

C. Financial Incentive Arrangements in Managed Care Are Beneficial to Both Patients and Physicians

Compensation arrangements that reward providers and consumers for achieving cost savings while delivering high quality care are a cornerstone of the American health care delivery system. Over the last decade, in an effort to control costs, traditional fee-for-service medicine has largely been replaced by a variety of forms of managed care, premised on encouraging both providers and enrollees to use limited health care dollars prudently. Such financial incentives for *providers* include risk-sharing arrangements such as payments on a capitated basis, provider withholds, discounted fees with bonuses, and global rates.¹³ For health care *consumers*, they

13. Capitation is "a method of payment in which a provider is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided." HEALTH INSURANCE ASSOCIATION OF AMERICA, *MANAGED CARE: INTEGRATING THE DELIVERY AND FINANCING OF HEALTH CARE*, PART A, 228 (1996). Withhold arrangements refer to "a portion of a provider's salary, fees, or capitation that is held back until performance in relation to quality and utilization are examined at the end of year." *Id.* at 240. Global rates allow certain procedures (such as expensive organ transplants) to be reimbursed at a single rate to include all professional and facility services. *See id.* at 230.

include responsibility for a portion of the bill through the almost universal use of deductibles and co-payments.

The court of appeals' view that physician incentive arrangements substantially erode the quality of American health care is contrary to every objective study of the issue. Financial incentives did not spring up with the advent of managed care. In fee-for-service medicine, for example, "there is a financial incentive to provide more services"¹⁴—perhaps even unnecessary services. More services, however, do not equate to better medical care, since they could be services that subject patients to a significant risk of complications and correlative diseases.¹⁵ The problem is serious: the recent report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has estimated that overutilization of medical services might "be as high as 30% of the total health care delivered in the United States."¹⁶

Not only does the empirical evidence indicate that physician incentive arrangements are actually effective in

14. Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence*, 53 MEDICAL CARE RESEARCH & REVIEW 294, 294 (1996).

15. *See* David W. Bates, David J. Cullin, Nan Laird, et al., *Incidence of Adverse Drug Events and Potential Adverse Drug Events: Implications for Prevention*, 274 JAMA 29, 29 (1995) (stating that "over a million patients are injured in hospitals each year, and approximately 180,000 die annually as a result of these injuries").

16. REPORT TO THE PRESIDENT OF THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, *QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS* 156 (1998).

limiting costs,¹⁷ but, more importantly, there are absolutely no definitive data supporting the court of appeals' position that reimbursement incentives exert a negative impact on overall quality of care. In fact, the opposite is true: "the literature in this area, including large studies of Medicaid and Medicare patients in managed care systems in the 1980s, consistently shows that *costs are lower in managed-care systems, with quality equal to or better than that in fee-for-service care.*"¹⁸

Statistically, for example, individuals like Ms. Herdrich who are suffering from appendicitis fare better in an HMO than in traditional fee for service plans.¹⁹ A study published in the New England Journal of Medicine revealed that ruptured appendices occurred in 34.3 percent of uninsured patients, 33.6 percent of Medicaid patients, 29.3 percent of patients with private insurance and in only 25.8 percent of the patients receiving care through managed care organizations.²⁰ Thus, the unsupported basis for the court of appeals' opinion — an assumption that managed care physicians are likely to sacrifice patient care for their pocketbook — is in direct conflict with the results of this

17. See Alan L. Hillman, et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 89 (1989).

18. Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1228 (1996) (*emphasis added*).

19. See Paula Breveman, *Insurance Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444, 444 (1994).

20. See *id.* at 446.

empirical study which found that to a "significant extent, patients covered by fee-for-services plans . . . appear to be at a disadvantage as compared to those covered by capitated private plans."²¹ The court of appeals, however, cites only articles and studies attacking managed care, while by-passing the many studies that praise managed care entities, especially with respect to their role in providing services to vulnerable populations and in reducing the incidence of fatalities from many forms of cancer.²²

A significant benefit of a capitated system is that it transfers more control over medical decision-making to the hands of treating physicians, rather than leaving such decisions to the financing entity. The court of appeals' assumption that financial incentives will cause physicians to ignore their professional and ethical obligations does a disservice to the profession while crippling benefit plan sponsors attempting to make the most of limited health care dollars.

D. The Decision Below Contravenes Uniform Federal and State Policy Permitting Cost Containment Measures in Health Plans

The court of appeals' disdain for cost containment mechanisms is not shared by either Congress or the state legislatures. The forms of financial risk sharing it condemns

21. *Id.* at 449.

22. See Gerald F. Riley, *Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees*, 84 AM. J. PUB. HEALTH 1598, 1598 (1994) (Medicare patients in HMOs are diagnosed with such cancers as breast, cervix, colon, and melanomas at an earlier stage as compared with fee-for-service enrollees).

are firmly grounded in legislative policy designed to eliminate the reverse incentives of "open checkbook" medicine. Systems of cost-savings have constituted the keystone of federal and state health care programs for the past quarter century. For example, the Federal Health Maintenance Organization Act of 1973²³ expressly authorizes HMOs to "make arrangements with physicians . . . to assume all or part of the financial risk."²⁴ Further, ERISA specifically proscribes to plan fiduciaries the duty to defray plan expenses and to preserve and maintain plan assets.²⁵

The court of appeals' diatribe against managed care is astonishing, given that every state as well as the District of Columbia regulates MCOs, either through a specific MCO statute or through its general insurance statute,²⁶ and relies on the expansion of HMOs and other forms of managed care to provide a "new alternative for the delivery of a full range of health care services *at a reasonable cost*."²⁷ A health plan may be self-insured and regulated under ERISA, or may be insured through an HMO, a preferred provider organization (PPO), or a combination such as a "point of service" (POS)

23. 42 U.S.C. § 300(e) (1973). The Act defines an HMO as a public or private entity that provides health services to enrollees *at a fixed cost*, without relation to the frequency, extent, or kind of health service actually furnished. 42 U.S.C. § 300(e)(b)(1).

24. 42 U.S.C. § 300(e)(c)(2)(D) (Supp. 1999).

25. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1).

26. AMERICAN ASSOCIATION OF HEALTH PLANS, *THE REGULATION OF HEALTH PLANS* 11 (1998).

27. N.Y. PUB. HEALTH LAW § 4400 (McKinney 1999) (*emphasis added*).

plan, and thus subject to state mandated cost-control measures, with detailed requirements respecting patient deductibles, audits of bills, and utilization review of medical claims.²⁸ Both self-insured and insured plans must comply with regulatory monitoring systems to ensure quality assurance standards for the care provided to enrollees, to ensure adequate disclosure to enrollees regarding the benefits and conditions of the plan, and to provide for a fair appeals and grievance procedure.²⁹

Congress itself formerly shared the court of appeals' bias against MCO cost containment practices, and at one time prohibited prepaid health care organizations that contracted with Medicare and Medicaid from making incentive payments to physicians.³⁰ Research studies by the Department of Health and Human Services, however, "failed to find a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans."³¹ Today, given the critical

28. See, e.g., ERISA § 503, 29 U.S.C. § 1133; FLA. STAT. ANN. § 627.4234 (West 1999).

29. See, e.g., FLA. STAT. ANN. §§ 641.17, *et seq.*; 215 ILL. COMP. STAT. 125/1-1 *et seq.*; N.J. STAT. ANN. §§ 26:2J-1, *et seq.*; TEX. INS. CODE ANN. art. 20A.01, *et seq.*

30. Omnibus Budget Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. 2002. The Omnibus Budget Reconciliation Act (OBRA) of 1990, Pub. L. No. 101-508, §§ 4204(a), 4731, 104 Stat. 1388-108, -195, repealed the prohibition on physician incentive plans in Medicare and Medicaid HMOs.

31. Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Healthcare Organizations, 57 FED. REG. 59,024 (proposed Dec. 14, 1992); Requirements for Physician Incentive Plans, 42 C.F.R. § 417.479 (1997).

necessity of medical cost control, physician incentives are aggressively promoted in both the Medicare and Medicaid programs as a cost conservation measure.³²

While provider incentive programs and other cost-containment mechanisms are now expressly encouraged, they also are subject to extensive regulation to protect enrollees. Congress limited the use of one common cost-containment mechanism — pre-existing condition exclusions — in the Health Insurance Portability and Accountability Act of 1996,³³ and has enacted recent legislation prohibiting physician incentives to limit care in specified situations.³⁴ Some states also have specifically forbidden arrangements between a health plan and healthcare providers whereby payments are made as an inducement for the provider to “deny, reduce, limit or delay specific, medically necessary and appropriate services.”³⁵ Health plans are held accountable for their decisions not only by such laws, but also by private accreditation agencies, such as the non-profit National

32. Social Security Act, 42 U.S.C. § 1395mm (Supp. 1999) (Medicare managed care); 42 U.S.C. § 1396b(m) (Supp. 1999) (Medicaid managed care); 42 U.S.C. § 1395w (Supp. 1999) (Medicare+Choice).

33. Health Insurance and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 2945; ERISA § 701, 29 U.S.C. § 1171; Public Health Service Act, §§ 2701, 2741, 42 U.S.C. §§ 300gg, 300gg-41.

34. *See* Newborns’ and Mothers’ Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935, §§ 603, 604; Women’s Health and Cancer Rights Act, Pub. L. No. 105-277, § 902, 112 Stat. 2681.

35. CAL. HEALTH & SAFETY CODE § 1348.6 (West 1999); *see also* N.J. ADMIN. CODE tit. 26, § 2H-18.51 (West 1997) (same).

Committee for Quality Assurance, which provides information enabling both plan sponsors and consumers of managed care to evaluate plans based on the quality of care provided.³⁶

There are few, if any, more highly regulated areas of the United States economy than employer-sponsored health care and the managed care industry. Yet the Seventh Circuit has concluded that all of the legislative and regulatory safeguards surrounding managed care’s relationship with ERISA plans are inadequate to protect consumers. There is no principled distinction between the court of appeals’ treatment of managed care organizations as particularly susceptible to financial-based conflicts involving decisions to provide care, and the conflicts present in the employer-financed health care industry or traditional fee-for-service insurance industry.³⁷

The court of appeals has disregarded both the considered judgment of Congress and the state legislatures that cost containment in health care is a necessity, as well as the myriad protections built into the system for health care consumers. On the basis of undocumented assumptions about the alleged adverse impact of MCO cost containment practices, the court has turned a virtue — the duty of an ERISA fiduciary to be financially prudent — into a punishable sin, with dire consequences for the limited health care dollars of every plan. Congress and state legislatures

36. The NCQA both accredits managed care plans in such areas as quality improvement, physician credentials, preventive health services, and utilization management, and provides specific performance measurement of plans using the Health Plan Employer Data and Information Set (HEDIS).

37. *See Herdrich*, 154 F.3d at 382 (Flaum, J. dissenting).

have determined that cost containment practices, properly structured and regulated, do not compromise the quality of medical care. Should it ever appear that some of those practices do have such an effect, then those legislatures have the authority and ability to step in to effect an appropriate cure.³⁸ The *Herdrich* majority's anti-managed care bias should not be allowed to override the carefully considered decision of the legislative and executive branches to promote the prudent and effective management of health plans.

E. ERISA Does Not, and Should Not, Provide an Alternate Remedy for Medical Malpractice

The court of appeals decision improperly equates ERISA fiduciary standards to medical malpractice standards, even though (1) ERISA does not allow any such equation, and (2) state tort law already provides relief if physicians render substandard care, just as Ms. Herdrich here was awarded damages for malpractice.³⁹

The *Herdrich* decision has unfortunately converted an ordinary tort claim into an unprecedented tort-based "breach of fiduciary duty" claim under ERISA. This is not a benign invention. By elevating the fiduciary duty owed to the individual participants of an employee benefit plan far above the duty owed to the plan as a whole, the decision literally prevents fiduciaries from fulfilling their statutory duty to

38. For example, Congress is currently debating enactment of a Patients' Bill of Rights Act providing additional protections for consumers. See Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. (1999).

39. See *Herdrich*, 154 F.3d at 367.

preserve and maintain plan assets.⁴⁰ The result: fiduciaries will be compelled to breach their statutory duties, as they are forced to purchase or administer plans without cost containment measures to appease individual plan members and to avoid liability for damages under this new judicially-created ERISA tort action. In the long run, of course, such an approach is counterproductive, as it depletes plan assets and inevitably places the health of those same plan members at serious risk.

There is no basis whatsoever in the text of statute or this Court's prior opinions for this novel tort-based "breach of fiduciary duty" claim, and this Court should not allow a court of appeals to create one. Although Ms. Herdrich purported to bring her claim "on behalf of the Plan,"⁴¹ no financial loss to the Plan flowed from Dr. Pegram's delay in scheduling Ms. Herdrich for medical services, and her personal loss provides no basis for remedial relief for the Plan under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Nor can Ms. Herdrich rely on Section 409 of ERISA, 29 U.S.C. § 1109, which allows participants to bring claims against a plan fiduciary who causes injury to the plan, and requires that the breaching fiduciary "make good to such plan losses to the plan." Nowhere in Ms. Herdrich's complaint does she allege that *any* action on the part of the HMO caused a financial loss to "the Plan," and indeed she cannot. The Plan would have realized a financial gain rather than a loss if it functioned as Ms. Herdrich alleged. Any cost savings realized as a result of physician incentives would necessarily *reduce*

40. See *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); see also *Central States, Southeast & Southwest Areas Pension Fund v. Central Transp., Inc.*, 472 U.S. 559, 569-70 (1985).

41. See *Herdrich*, 154 F.3d at 362.

rather than *increase* the costs to the Plan for purchasing health benefits.

The Seventh Circuit's creation of a new fiduciary standard unsupported by ERISA is not a harmless aberration. The *Herdrich* decision can be invoked any time cost-saving mechanisms — the essence of employer-sponsored health care plans and managed care — are in place.⁴² Yet health plan enrollees already have a remedy for inadequate quality of medical services in medical malpractice law.⁴³ The court of appeals' decision in *Herdrich* not only blurs the line between medical malpractice standards and ERISA fiduciary standards, but also constitutes impermissible "judicial policymaking" by disregarding the express policy determinations of Congress, the Executive Branch and state legislatures mandating cost saving measures in health care. Most significantly, it irreparably harms the ability of ERISA fiduciaries, employers, plan administrators, and MCOs to sustain our current system of employer-based health coverage on which millions of Americans depend.

CONCLUSION

For the above reasons, Amici, HIAA, AAHP, APPWP and the Chamber, respectfully request that this Court grant the Petition for Certiorari.

42. *Herdrich* has already been relied upon to allow a breach of fiduciary duty claim against an HMO doctor on the basis of the perceived financial tension between the doctor's and clinic's financial well being and the patient's welfare. See *Neade v. Portes*, 710 N.E.2d 418, 424-25 (Ill. App. Ct. 1999). While *Herdrich* emphasized that it did not intend to open the floodgates of litigation, the *Neade* decision, guided by the authority of *Herdrich*, accomplishes exactly that result.

43. See *DeLucia v. Saint Luke's Hosp.*, No. 98-6446, 1999 U.S. Dist. LEXIS 8124, at *10 (E.D. Pa. May 24, 1999).

Respectfully submitted,

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APPENDIX

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**APPENDIX — COMPILATION OF RELEVANT
STUDIES AND ARTICLES**

(Omitted here but submitted separately
as Lodging Appendix)

No. 98-1949

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Supreme Court, U.S.

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IN THE
Supreme Court of the United States

LORI PEGRAM, M.D.,
CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

JOINT APPENDIX

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TABLE OF CONTENTS

Page

District Court Docket Entries 1

Court of Appeals Docket Entries 24

Group Medical Health Plan:
Summary Plan Description (Jan. 1, 1991) 31

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
(PEORIA)**

Docket No. 94-CV-1143

CYNTHIA HERDRICH,

Plaintiff,

v.

LORI PEGRAM, M.D., *et al.*,

Defendants.

DOCKET ENTRIES

DATE	NO	PROCEEDINGS
3/14/94	1	NOTICE OF REMOVAL from McLean County Case Number: 92-L-254 Case referred to Mag. Judge Charles H. Evans. Complaint filed 10/21/92 in McLean County. Summonses issued 10/22/92. (bn) [Entry date 03/16/94] [Edit date 03/29/94]
3/14/94		FILING FEE PAID on 3/14/94 in the amount of \$ 120.00 receipt # 014782. (bn) [Entry date 03/16/94]
3/14/94	2	NOTICE of Removal of Cause by Lori Pegram, Carle Clinic Assoc, Health Alliance MP (bn) [Entry date 03/16/94]
3/14/94	3	NOTICE of filing Notice of Removal of Cause by Lori Pegram, Carle Clinic Assoc, Health Alliance MP (bn) [Entry date 03/16/94]
3/14/94	4	CERTIFICATE OF INTEREST pursuant to Local Rule 1.6 filed by Lori Pegram, Carle

DATE		PROCEEDINGS
		Clinic Assoc, Health Alliance MIP (bn) [Entry date 03/16/94]
3/17/94	5	ORDER by Judge Richard Mills transferring case to the Peoria Division (cc: all counsel) (bn)
3/17/94		Original file, certified copy of transfer order and docket sheet received from Springfield [94-3063]. Case assigned to Chief Judge Michael M. Mihm. Case referred to Mag. Judge Robert J. Kauffman. (bn)
3/29/94	6	TRANSFER LETTER (con mag&certificate of interest forms also to Pltf's. Atty.) sent to all attys. of record by clerk. (hw) [Edit date 03/29/94]
3/29/94	--	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ;cse set for telephone status conference at 4:15 p.m. on Friday, 4/29/94; court to set up call. (cc: all counsel) (ds) [Entry date 03/31/94]
4/8/94	7	MOTION by plaintiff Cynthia Herdrich to remand (ds) [Entry date 04/11/94]
4/19/94	8	MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to extend time (ds)
4/22/94	--	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman granting motion to extend time [8-1] to respond to motion to remand [7-1]; deadline for response is 5/20/94. (cc: all counsel) (ds)
4/22/94	9	AMENDED MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to extend time to respond to the motion to remand to and including 5/20/94. (ds) [Entry date 04/29/94] MTNDDL 15

DATE		PROCEEDINGS
4/26/94	--	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ; Status hearing previously set for 4:15 on 4/29/94 is reset to Monday, 6/6/94 at 3:30 p.m. via phone, court to call. (cc: all counsel) (ds)
5/20/94	10	MEMORANDUM IN OPPOSITION motion to remand [7-1] by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (ds)
5/23/94	11	RESPONSE in opposition by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to motion to remand [7-1] (ds)
6/6/94	--	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ; Attorneys Ginzkey and Brandt present via phone for status hearing held at 3:30 6/6/94 Court grants motion to extend time to respond to the motion to remand to and including [9-1] pro nunc tunc; takes under advisement on 6/6/94 motion to remand [7-1] (cc: all counsel) (ds) [Entry date 06/09/94]
7/22/94	12	MAGISTRATE'S RECOMMENDATION re: motion to remand [7-1] by Cynthia Herdrich by Mag. Judge Robert J. Kauffman. Recommending that motion to remand (#7) be denied and that defendants be ordered to answer Counts 3 and 4 within 10 days of the decision of the court on this motion. Case referral terminated. (cc: all counsel) (cl) [Edit date 08/22/94]
8/5/94	13	ORDER by Chief Judge Michael M. Mihm granting report & recommendation [12-1], and denying motion to remand [7-1]. Defendants are ordered to answer Counts 3 and 4 of the amended complaint by ; Mtn filing ddl of 8/26/94, Case referred to Mag. Judge J. Kauffman (cc: all counsel) (cl)

DATE	PROCEEDINGS
10/14/94 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ; Status hearing set 9:00 Thursday, 11/3/94 by phone. Court to set up call.(cc: all counsel) (cl)
11/3/94 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Attorneys Ginzkey/Brandt present by phone and ; Status hearing held 9:00 11/3/94 ;Court orderes [sic] answer to be filed within 7 days (11/10/94). Discovery to be completed by 6/30/95, ; Court sets Mtn filing ddl of 7/31/95 for filing of dispositive motions (cc: all counsel) (cl) [Entry date 11/04/94]
11/8/94 14	ANSWER TO ADDENDUM TO COMPLAINT by defendant Carle Clinic Assoc (cl)
12/29/94 15	NOTICE of Service of Discovery Documents by plaintiff Cynthia Herdrich (cl) [Entry date 12/30/94]
1/17/95 16	MOTION by defendant for summary judgment (cl) MTNDDL 15 [Entry date 01/18/95]
1/17/95 17	MEMORANDUM IN SUPPORT of motion for summary judgment [16-1] by defendants (cl) [Entry date 01/18/95] [Edit date 07/30/96]
1/18/95 18	NOTICE OF SERVICE OF DISCOVERY DOCUMENTS by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (hw)
2/9/95 19	MOTION by plaintiff Cynthia Herdrich for extension of time (hw)
2/9/95 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Plaintiff's response to motion for summary judgment was due on February 3, 1995. Plaintiff's motion for extension of time was not filed until six (6) days after the deadline. Plaintiff's counsel is put on notice that any further disregard of deadlines set in this

DATE	PROCEEDINGS
	matter will result in sanctions. The motion for extension of time [19-1] is GRANTED. Plaintiff's resepnse [sic] to motion for summary judgment [16-1] must be filed no later than 2/23/95 (cc: all counsel) (cl) [Entry date 02/10/95]
2/23/95 20	RESPONSE by plaintiff Cynthia Herdrich to motion for summary judgment [16-1] with exhibits (cl)
2/23/95 21	MEMORANDUM IN OPPOSITION motion for summary judgment [16-1] by plaintiff Cynthia Herdrich (cl)
2/23/95 22	MOTION by plaintiff Cynthia Herdrich to amend complaint (cl)
2/23/95 23	MOTION by plaintiff Cynthia Herdrich to compel discovery (cl)
3/6/95 24	RESPONSE by defendants to motion to compel discovery [23-1] (cl)
3/13/95 25	NOTICE OF SERVICE OF DISCOVERY DOCUMENTS by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (vf)
3/17/95 26	REPLY by defendants to response to motion for summary judgment [16-1](d)
3/20/95 27	MOTION by defendant for leave to file reply in support of summary judgment (cl)
3/21/95 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion for leave to file reply in support of summary judgment [27-1] (cc: all counsel) (cl) [Entry date 03/22/95]
3/30/95 28	3rd AMENDED NOTICE by plaintiff Cynthia Herdrich of taking deposition of Benjamin H. Robbins on May 23, 1995 (cl) MTNDDL 15

DATE	PROCEEDINGS
7/25/95 29	ORDER by Chief Judge Michael M. Mihm granting in part and denying in part the motion to amend complaint [22-1], in that dft to file amended complaint as to count 3 within 14 days; granting in part and denying in part the motion for summary judgment [16-1] dismissing Count IV in favor of Dft Health Alliance with costs; to dismiss party Health Alliance MP Court sets ; Mtn filing ddl of 8/8/95 for Pla to replead Count III (see order) (cc: all counsel) (cl)
8/8/95 30	MOTION by plaintiff Cynthia Herdrich for leave to file to name Carle Health Insurance Management Co., Inc. as a party defendant (kw2) [Entry date 08/10/95]
9/1/95 31	AMENDED COMPLAINT by plaintiff Cynthia Herdrich [1-2]; adding Health Alliance MP, Carle Health Ins (cl) [Entry date 09/07/95]
9/5/95 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion for leave to file to name Carle Health Insurance Management Co., Inc. as a party defendant [30-1] (cc: all counsel) (cl)
9/7/95 32	RESPONSE by defendant to plaintiff's motion for leave to amend [30-1] (cl)
9/14/95 33	WAIVER OF SERVICE returned by defendant Carle Health Ins on 9/12/95; Answers due on 1 1/13/95 for Carle Health Ins (cl)
9/29/95 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion to compel discovery [23-1] as to the document production requests. If the deposition of Dr. Benjamin Robbins has not yet been scheduled, the parties are ordered to arrange that deposition within 28 days from the entry of this order. Defts like-

DATE	PROCEEDINGS
	wise have 28 days to produce the requested documents. (cc: all counsel) (cl)
11/14/95 34	MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP, defendant Carle Health Ins to dismiss (lr) [Entry date 11/15/95]
11/14/95 35	MEMORANDUM IN SUPPORT of motion to dismiss [34-1] by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP, defendant Carle Health Ins (lr) [Entry date 11/15/95]
11/15/95 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm Case referred to Mag. Judge Robert J. Kauffman for further proceedings on the motion to dismiss. (cc: all counsel) (lr) [Entry date 11/16/95]
11/20/95	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman setting hearing re motion to dismiss [34-1] at 1:30, Friday, 12/1/95 via phone. Court to call. (cc: all counsel) (lr) MTNDDL 15
11/27/95 36	RESPONSE by plaintiff Cynthia Herdrich to motion to dismiss [34-1] (lr)
11/27/95 37	MEMORANDUM IN SUPPORT of motion response [36-1] by plaintiff: Cynthia Herdrich (lr)
11/28/95 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Hearing re motion to dismiss [34-1] hearing set for 1:30, Friday, 12/1/95 is CANCELLED and RESET for 9:00, Thursday, 12/14/95 via phone. Court to call. (cc: all counsel) (lr)
12/14/95 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Parties present via phone by Attys Ginzkey/Brandt for Motion hearing re: motion

DATE	PROCEEDINGS
	to dismiss (#34). Same held at 9:00 Thursday, 12/14/95. Argument by counsel. Court is taking under advisement on 12/14/95 motion to dismiss [34-1]. (cc: all counsel) (vf)
2/5/96 38	NOTICE of service of discovery documents by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP, defendant Carle Health 08/10/95] Ins (lr)
3/26/96 39	MAGISTRATE'S RECOMMENDATION re: motion to dismiss [34-1] by Carle Health Ins, Health Alliance MP, Carle Clinic Assoc, Lori Pegram recommended motion to dismiss [34-1] be allowed and that the plaintiff be given on last chance to re-plead the ERISA claim by Mag. Judge Robert J. Kauffman; Case referral terminated. (cc: all counsel) (lr)
4/4/96 40	RULE 72 OBJECTIONS by plaintiff Cynthia Herdrich to magistrate's recommendation [39-1] (vf)
4/11/96 41	RESPONSE by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to Rule 72 Objection [40-1] (lr)
4/15/96 42	ORDER by Chief Judge Michael M. Mihm denying report & recommendation objection [40-1], granting report & recommendation motion re: motion to dismiss [34-1] by Carle Health Ins, Health Alliance MP, Carle Clinic Assoc, Lori Pegram [39-1], and granting motion to dismiss [34-1]. Herdrich has 21 days from the entry of this Order to replead her Count II ERISA claim. Motion filing ddl to replead is 5/6/96. Case referred to Mag. Judge Robert J. Kauffman. (cc: all counsel) (seal)
4/26/96 43	MOTION by plaintiff Cynthia Herdrich to remand (lr) [Entry date 04/29/96]

DATE	PROCEEDINGS
5/6/96 44	RESPONSE by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to motion to remand [43-1] (lr) MTNDDL 15
5/6/96 45	MEMORANDUM [N SUPPORT of motion response [44-1] by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (lr)
5/10/96 46	MEMORANDUM [N SUPPORT of motion to remand [43-1] by plaintiff Cynthia Herdrich (lr)
5/13/96 47	ORDER by Chief Judge Michael M. Mihm denying motion to remand [43-1]. Case referred to Mag. Judge Robert J. Kauffman. See Order. (cc: all counsel) (lr)
5/20/96 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman; Status hearing set for 11:00, Friday, 5/31/96 via phone. Court to call. (cc: all counsel) (lr) [Entry date 05/21/96]
5/31/96 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Parties present via phone by Attys Ginzkey/P Brandt for Status hearing held at 11:00 Friday, 5/31/96. Plaintiff stands on Count II as is. Parties are ready for Final Pretrial conference. (cc: all counsel/Judge Mihm) (vf)
6/28/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm; Final Pretrial conference set for 2:00, Thursday, 8/1/96 in person in Peoria. (cc: all counsel w/FPT notice) (lr) [Entry date 07/01/96]
8/1/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Attys. Ginzkey/Brandt present in person and final pretrial conf held 8/1/96. (Medical malpractice claims remain.) Any motions in limine and the stipulation of

DATE	PROCEEDINGS
	uncontested facts are to be filed by Mtn filing ddl of 8/29/96; response to motions in limine to be filed by misc ddl of 9/19/96. Jury trial set for 8:30a.m. Mond 12/2/96 (4 day trial) (cc: all counsel) (cl) [Entry date 08/02/96]
8/1/96 48	PRETRIAL ORDER entered by Chief Judge Michael M. Mihm : (cl) [Entry date 08/02/96]
8/1/96 49	EXHIBIT LIST by defendants (cl) [Entry date 08/02/96]
8/1/96 50	WITNESS LIST submitted by defendants (cl) [Entry date 08/02/96]
8/1/96 51	JURY INSTRUCTIONS submitted by defendants (cl) [Entry date 08/02/96]
8/1/96 52	EXHIBITS/ATTACHMENT to final pre-trial order for defendant (cl) [Entry date 08/02/96] MTNDDL 15
8/9/96 54	SECOND MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring [sic] to, interrogating concerning, and/or attempting to convey to the jury that there is insurance (lr) [Entry date 08/12/96] [Edit date 08/12/96]
8/9/96 53	MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP in limine (lr) [Entry date 08/12/96]
8/15/96 55	MOTION by plaintiff Cynthia Herdrich in limine to order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis etc (lr)

DATE	PROCEEDINGS
8/19/96 56	STIPULATION STATEMENT OF UNCONTESTED FACTS AND ISSUES OF LAW by plaintiff Cynthia Herdrich (lr) [Entry date 08/21/96]
11/6/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm setting telephone conference call re motion in limine to order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis etc [55-1], motion in limine [53-1], and motion in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring to, interrogating concerning, and/or attempting to convey to the jury that there is insurance [54-1] at 9:00, Tuesday, 11/12/96, via phone. Court to call. (cc: all counsel) (lr) [Edit date 11/27/96] MTNDDL 15
11/12/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Brandt for motion hearing on Tuesday, November 12, 1996, at 9:00 a.m. re motion in limine to order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis etc [55-1] and motion in limine [53-1], and motion in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring to, interrogating concerning, and/or attempting to convey to the jury that there is insurance [54-1]. Same held. Parties state they have discussed their motions and that neither side has any objections to the motions. Court is granting motion in limine to

DATE	PROCEEDINGS
	order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis [55-1], motion in limine [53-1], and motion in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring to, interrogating concerning, and/or attempting to convey to the jury that there is insurance [54-1]. Case remains set for jury trial on Monday, December 2, 1996, at 8:30 am. (cc: all counsel) (ml) [Edit date 11/12/96]
11/20/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm ; Status hearing set for 1:15, Monday, 11/25/96 via phone. Court to call. (cc: all counsel) (lr)
11/25/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Attys. Ginzkey/Brandt present by phone and status hearing held 1:15 11/25/96. Jury trial remains set 12/2/96. (cc: all counsel) (cl)
11/27/96 57	VOIR DIRE submitted by plaintiff Cynthia Herdrich (lr)
11/29/96 58	SUBPOENA filed by plaintiff Cynthia Herdrich as to Jan Kotynek, M.D. as executed (lr) [Entry date 12/02/96]
12/2/96 59	Proposed VOIR DIRE submitted by defendants (cl)
12/2/96 --	MINUTE-ENTRY:by Chief Judge Michael M. Mihm. Parties present in open court, Atty Ginzkey for Pltf & Atty Brandt for Deft. Parties announce readiness. Jury trial commences 8:30 12/2/96. Prospective jurors sworn, questioned & selected (8). Preliminary instructions by court. Juror Ella Maxwell excused from

DATE	PROCEEDINGS
	panel. Opening statements made by counsel. Out of presence of jury, previously ruled upon motion in limine argued. Jury now present & Pltf presents evidence. Deposition of Carlton King read to jury. Jury Trial continued until 9:00am for jurors & 8:45 for attys on Tuesday, 12/3/96 (cc: all counsel) (hw) [Entry date 12/04/96] MTNDDL 15
12/2/96 61	STIPULATION regarding nature of the case. (cl) [Entry date 12/05/96]
12/3/96 60	MEMORANDUM OF LAW on Issue of Increased Risk by defendants Lori Pegram & Carle Clinic Assoc (re:motion to exclude all evidence direct or indirect, that pltf might suffer an appendicitis attack in the future) (hw) [Entry date 12/04/96]
12/3/96 --	MINUTE-ENTRY:by Chief Judge Michael M. Mihm. Attys Ginzkey for Pltf & Brandt for Defts present in open court for continued jury trial. Jury now present & trial resumes with further evidence presented on behalf of Pltf. Pltf rests. Jury Trial continued until Wed, 12/4/96 at 9:00am. (cc: all counsel) (hw) [Entry date 12/04/96]
12/4/96 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Attys Ginzkey/Brandt w/parties present in person and trial continues with evidence by Dft. Dft rests. Rebuttal evidence by Pla. Pla rests. Closing arguments by counsel. Jury instructions by Court. Bailiffs sworn. Jury feed. Jury returns in open Court w/verdict at 7:55 p.m. in favor of Pla aind against Dfts for total damages of \$50,000.00, with 30% negligence attributable solely to Pla, therefore \$35,000 recoverable damages attributable to Pla. Jury polled. Berdicts [sic] entered of record. Jury discharged. ; Jury trial ended. Case

DATE	PROCEEDINGS
	terminated. Judgment to enter. (cc: all counsel) (cl) [Entry date 12/05/96]
12/4/96 62	EXHIBIT LIST (cl) [Entry date 12/05/96]
12/4/96 63	VERDICT for plaintiff Cynthia Herdrich against defendant Lori Pegram, defendant Carle Clinic Assoc (cl) [Entry date 12/05/96]
12/4/96 64	JURY [NSTRUCTIONS submitted to jury for deliberations (cl) [Entry date 12/05/96]
12/5/96 65	JUDGMENT in a civil case entered. Dfts Health Alliance Medical Plans and Carle Health Ins Co are dismissed on 4/15/96; Judgment is entered in favor of Pla and against Dfts Lori Pegram and Carle Clinic Assoc as employer of Dft Lori Pergam in the amount of \$50,000 total damages with 30 % negligence attributable to pla with recoverable damages in the sum of \$35,000 plus costs of suit. (cc: all counsel) (cl)
12/16/96 66	MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc for judgment after trial (lr) [Entry date 12/17/96] MTNDDL 15
12/16/96 67	MEMORANDUM IN SUPPORT (filed as Briefing Support of post-trial motion) of motion for judgment after trial [66- 1] by defendant Lori Pegram, defendant Carle Clinic Assoc (lr) [Entry date 12/17/96]
1/2/97 68	MEMORANDUM IN OPPOSITION motion for judgment after trial [66-1] by plaintiff Cynthia Herdrich (lr) [Entry date 01/03/97] [Edit date 01/06/97]
1/6/97 69	NOTICE of APPEAL by plaintiff Cynthia Herdrich from Dist. Court decision dated 4/15/96 [42-3] (cc: all counsel) (lr)
1/6/97 70	Received appeal fee in amount of \$ 105.00 (Receipt # 023566) (lr)

DATE	PROCEEDINGS
1/6/97 71	SHORT RECORD ON APPEAL sent to USCA (lr)
1/8/97 72	JURISDICTIONAL DOCKETING STATEMENT filed by plaintiff Cynthia Herdrich (lr)
1/14/97 73	ORDER by Chief Judge Michael M. Mihm denying motion for judgment after trial [66-1]. See Order. (cc: all counsel) (lr)
1/15/97 74	Notification by USCA of Appellate Docket Number 97- 1 070 (lr) [Entry: date 01/16/97]
1/16/97 75	REPLY by defendant Lori Pegram, defendant Carle Clinic Assoc to response to motion for judgment after trial [66-1] (lr)
1/27/97 76	BILL OF COSTS submitted on behalf of plaintiff Cynthia Herdrich in the sum of \$232.00. This notice is mailed to all parties with copy of the proposed bill of costs. Costs to be taxed at noon on Monday, 2/10/97 if not objections are filed. (hw)
2/10/97 77	AMENDED JUDGMENT in a civil case entered. Defts Health Alliance Medical Plans, Inc & Carle Health Ins Co., Inc are dismissed on 4/15/96. Judgment is entered in favor of Pltf & against Defts Lori Pegram & Carle Clinic Assoc as employer of Deft Lori Pegram in the sum of \$50,000.00 total damages with 30% negligence attributable to Pltf Cynthia Herdrich with recoverable damages in the sum of \$35,000.00 plus costs of suit. Further that on 2/10/97, costs are taxed in favor of Pltf & against Defts in the sum of \$232.00 (cc: all counsel) (hw)
4/4/97 78	SATISFACTION OF JUDGMENT as to defendant Carle Clinic Assoc (lr) [Entry date 04/07/97]

DATE	PROCEEDINGS
5/27/97 79	MOTION by plaintiff Cynthia Herdrich for order to withdraw record (vg) [Entry date 05/28/97] MTNDDL 15
5/29/97 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion for order to withdraw record [79-1] (cc: all counsel) (vg)
5/30/97 80	RECEIPT to Atty James P Ginzkey with one volume of pleadings of record on appeal (vg)
6/5/97 81	RECEIPT from Atty Ginzkey of receipt of record on appeal (vg)
7/18/97 82	STIPULATION regarding transfer of record from defendant's counsel to plaintiff's counsel. (vg) [Entry date 07/21/97]
7/22/97 --	MINUTE-ENTRY: by Chief Judge Michael M. Mihm. On July 18, 1997, the parties in this action filed a stipulation regarding the transfer of the record from one counsel to the other in order to prepare appellate briefs. However, despite the agreement of counsel, this procedure is inappropriate and contrary to the procedure set forth in Local Rule 79.2. Accordingly, counsel in possession of the record must return it to the Clerk's Office, who will then facilitate the transfer of the record to opposing counsel as per the standard operating procedure of this Court in accordance with the Local Rules. (cc: all counsel) (vg)
7/29/97 83	Remark-received from James P Ginzkey the record on appeal consisting of one volume of pleadings (vg) [Entry date 07/30/97]
10/21/97 84	NOTICE of oral argument from CA 7 with request for record on appeal (vg)
10/22/97 85	Letter of transmittal to USCA with one volume of pleadings (vg)

DATE	PROCEEDINGS
10/22/97 --	CLERK'S RECORD on appeal transmitted to USCA consisting of one volume of pleadings (vg)
11/3/97 86	Letter of transmittal from USCA acknowledging receipt of 1 vol of ROA (kd) [Edit date 11/04/97].
12/9/98 87	COPY of USCA Order: It is ordered that the aforesaid petition for rehearing be, and the same hereby is, DENIED. (ww)
12/11/98 88	COPY of USCA Order: The court, on its own motion, hereby withdraws the order of 12/7/98 in the case Herdrich v. Pegram. (ww)
12/17/98 89	MANDATE from USCA denying petition for rehearing [69-1]. ORDERED that the aforesaid petition for rehearing be, and the same hereby is, DENIED. (ml)
12/17/98 --	RECORD ON APPEAL returned from U.S. Court of Appeals consisting of one volume of pleadings. (ml) MTNDDL 15 [Entry date 01/29/99]
1/8/99 90	USCA Order: The Court, on its own motion, VACATED the mandate and Bill of Costs of 12/15/98 as erroneously issued. (ww)
1/29/99 --	CLERK'S RECORD on appeal transmitted to USCA again pursuant to telephone call from CA-7 requesting it due to order vacating mandate. (ml)
2/3/99 91	RECEIPT for Complete Record on Appeal by UCSA (sh)
3/17/99 --	RECORD ON APPEAL returned from U.S. Court of Appeals consisting of one volume of pleadings (ww)
3/22/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Case set for Status hearing re:mandate

DATE	PROCEEDINGS
	on Tuesday, 3/23/99 at 3:00 pm; via phone, Court to set up the call. (cc: all counsel) (hw)
3/23/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Brandt for Status hearing at 3:00 pm on Tuesday, 3/23/99. Same held with discussion re: mandate. Case is set for Supplemental Rule 16 Conference at 4:00 pm on Friday, 4/9/99, via phone. Court to call. (cc: all counsel) (ml) [Entry date 03/25/99]
4/7/99 92	PROPOSED DISCOVERY PLAN filed by plaintiff Cynthia Herdrich and defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Ins (ww)
4/9/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Attys Ginzkey/ Brandt present by phone and Supplemental Rule 16 conference held 4:00 4/9/99. Plaintiff to amend pleadings/join parties no later than 7/1/99; fact discovery to be completed by 8/1/99; plaintiff to disclose expert by 8/1/99; expert to be deposed by 9/1/99; defendant to disclose expert by 11/1/99 and expert to be deposed by 12/1/99. All discovery to close 12/1/99. Dispositive motions to be filed no later than Mtn filing ddl of 12/1/99; response to be filed by misc ddl of 12/22/99. Final Pretrial conference set 1:00 p.m. Friday, 2/25/2000 in person in Peoria. Jury trial set 8:30a.m. Monday, 3/27/2000 in Peoria. Status hearing set at 4:45p.m. Wednesday, 7/7/99 by phone. Court to set up call. (cc: all counsel) (ci) [Entry date 04/1 3/99] [Edit date 05/03/99]
4/9/99 --	ENDORSED ORDER on its face by Judge Michael M. Mihm adopting proposed Rule 16 schedule #92 with changes. (See order) (cc: all counsel). (cl) [Entry date 04/13/99]

DATE	PROCEEDINGS
4/26/99 93	MOTION by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Health Ins to stay (ww) MTNDDL 15
4/26/99 94	BRIEF IN SUPPORT of motion to stay [93-1] by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Ins (ww)
4/30/99 95	RESPONSE in Opposition by plaintiff Cynthia Herdrich to motion to stay [93-1](ww)
4/30/99 96	MEMORANDUM IN SUPPORT of opposition [95-1] to stay [93-1] filed as a brief by plaintiff Cynthia Herdrich (ww)
4/30/99 97	2ND MOTION by plaintiff Cynthia Herdrich to compel (ww)
5/6/99 98	RESPONSE by defendants Lori Pegram, Carle Clinic Assoc and Health Alliance MP to second motion to compel [97-1] (ww)
5/21/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Defendant's motion to stay [93-1] is DENIED. Additionally, Plaintiff's motion to compel [97-1] is GRANTED. Defendant's sole argument in response to the motion to compel is that the "motion is untimely and premature since the question whether Plaintiff's complaint states a cause of action. . . remains unanswered." The question has been answered, as the Seventh Circuit issued its mandate. Furthermore, because the Seventh Circuit issued its mandate, Fed. R. Civ. P. 27(b) is inapplicable. Consequently, discovery in this case will progress in accordance with the schedule established by the Court on 4/9/99. This case is referred to the Mag. Judge Robert J. Kauffman. (cc: all counsel) (ww)
6/22/99 99	STIPULATED MOTION by pla Cynthia Herdrich and dfts Lori Pegram, Carle Clinic As-

DATE	PROCEEDINGS
	soc, Health Alliance MP and Carle Health Ins to amend rule 16 schedule (ww)
7/7/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Attys Ginzkey/ Steitz (for Brandt) present by phone and status hearing held 4:45 7/7/99. Court is granting motion to amend Rule 16 schedule [99-1]. Court resets schedule of case as follows: Previous discovery schedule is vacated. All discovery closes 2/15/00. Dispositive motions to be filed no later than Mtn filing ddl of 3/10/00; response to be filed by misc ddl of 3/31/00. Any reply to be filed by 4/7/00. Final pretrial conference is reset to 1:00 Friday, 6/16/00 in person in Peoria. Jury trial is reset to 8:30 Monday, 8/21/00 in Peoria. Case to be set for settlement conference at a time to be determined by Magistrate Judge Robert J. Kauffman. (cc: all counsel/ Prob/USM/ Crt Rptr) (cl) [Entry date 07/08/99]
7/8/99 100	AMENDED RULE 16 Schedule by Judge Michael M. Mihm. Discovery to be completed by 2/15/00. Final Pretrial conference set at 1:00 p.m. on Wednesday, 6/16/00 in person. Jury trial set at 8:30 am. on Monday, 8/21/00 in person. Dispositive motion filing ddl of 3/10/00. Replys to be filed by 4/7/00. (cc: all counsel) (ww) MTNDDL 15
7/16/99 101	MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to continue/reschedule final pre-trial conference (hw)
7/16/99 102	AFFIDAVIT of Peter W. Brandt regarding motion to continue/reschedule final pre-trial conference [101-1] (hw)
7/27/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Defendants' motion to continue/re-

DATE	PROCEEDINGS
	schedule final pre-trial conference [101-1] is GRANTED. The Court will contact the parties shortly to reschedule the conference. (cc: all counsel) (ww) [Entry date 07/28/99]
7/28/99 103	NOTICE by plaintiff Cynthia Herdrich of service of discovery documents
7/30/99 104	MOTION by defendants Lori Pegnam, Carle Clinic Assoc and Health Alliance MP to strike jury demand (ww)
7/30/99 105	MEMORANDUM IN SUPPORT of motion to strike jury demand [104-1] by defendants Lori Pegnam, Carle Clinic Assoc and Health Alliance MP (ww)
8/3/99 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman setting motion hearing in re motion to strike jury demand [104-1] at 9:30 am. on Monday, 8/23/99 via phone. Court to set up the call. (cc: all counsel) (ww)
8/3/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Final pretrial conference previously [sic] scheduled on 6/16/00 (canceled in minute entry of 7/27/99) is rescheduled to Wednesday, 6/14/00 at 4:30 p.m. in person. (cc: all counsel) (ww)
8/9/99 106	RESPONSE by plaintiff Cynthia Herdrich to motion to strike jury [104-1] (ww)
8/10/99 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman granting motion to strike jury demand [104-1] (cc: all counsel) (ww)
8/12/99 107	NOTICE of service of discovery documents by defendants Lori Pegram, Carle Clinic Assoc and Health Alliance MP (ww)
8/17/99 --	MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Motion hearing set 8/23/99 at 9:30 am. in re motion to strike jury demand [104-1]

DATE	PROCEEDINGS
	is cancelled per ruling on motion on 8/10/99. (cc: all counsel) (ww)
9/1/99 108	MOTION by plaintiff Cynthia Herdrich to extend time to complete fact discovery and expert disclosure (ww) MTNDDL 15
9/3/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm setting motion to extend time to complete fact discovery and expert disclosure [108-1] for hearing at 1:00 p.m. on Tuesday, 9/7/99, via phone. Court to call. (cc: all counsel) (ml)
9/7/99 109	NOTICE of service of discovery documents by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MIP, and Carle Health Ins (ww)
9/7/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Peter Brandt for motion Hearing on Tuesday, September 7, 1999, at 1:00 p.m. re motion to extend time to complete fact discovery and expert disclosure [108-1]. Same held. Court is granting motion to extend time to complete fact discovery and expert disclosure [108-1] and sets the following schedule: Disclosure of plaintiff's experts to be completed by 11/12/99 and plaintiff's expert discovery to be completed by 12/24/99. Defendants' experts to be disclosed by 1/14/2000. Fact discovery deadline is 10/29/99. The deadline for the close of all discovery remains unchanged at 2/15/2000. (cc: all counsel) (ml)
10/1/99 110	RENEWED MOTION by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MIP and Carle Health Ins for stay (ww)
10/1/99 111	BRIEF/MEMORANDUM IN SUPPORT of motion for stay [110-1] by defendants Lori

DATE	PROCEEDINGS
	Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Ins (ww)
10/6/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm setting case for motion hearing on renewed motion for stay [110-1] at 2:00 p.m. on Thursday, 10/7/99, via phone. Court to call. (cc: all counsel) (ml) [Entry date 10/07/99]
10/7/99 --	MINUTE-ENTRY: by Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Brandt for motion hearing at 2:00 p.m. on Wednesday, October 7, 1999 re Defendants' renewed motion for stay [110-1]. Same held. Order will enter ordering case stayed until Supreme Court rules on it. (cc: all counsel) (ml)
10/7/99 112	ORDER by Judge Michael M. Mihm granting defendants' renewed motion for stay [110-1]. ORDERED that this action is STAYED pending the Supreme Court's disposition of Pegram v. Herdrich, No. 98-1949. (cc: all counsel) (ml)

**UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

Docket No. 97-1070

CYNTHIA HERDRICH,
Plaintiff-Appellant,
v.
LORI PEGRAM, M.D., *et al.,*
Defendants-Appellees.

DOCKET ENTRIES

DATE	PROCEEDINGS
1/10/97	Private civil case docketed. [97-1070] [907331-1] Appearance form due on 2/10/97 for Peter W. Brandt, for James P. Ginzkey. Transcript information sheet due 1/21/97. Appellant's brief due 2/19/97 for Cynthia Herdrich. Docketing Statement due 1/13/97. (tim)
1/17/97	Filed Appellant Cynthia Herdrich docketing statement. [97-1070] [909045-1] (chuc)
1/27/97	NOTICE: Peter W. Brandt for Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram will not be available for oral argument March 21 - April 4, 1997. [97-1070] [907331-1] (broo)
1/27/97	Appearance form filed by attorney(s) James P. Ginzkey for Appellant Cynthia Herdrich. [97-1070] [907331-1] (madd)
2/4/97	Appearance form filed by attorney(s) Peter W. Brandt for Appellee Lori Pegram, Appellee Carle Clinic Assoc, Appellee Health Alliance. [97-1070] [907331-1] (madd)

DATE	PROCEEDINGS
2/6/97	ORDER: On review of the short record, it appears that a timely post-decision motion was filed in the District Court. Appellant(s) shall file a jurisdictional memorandum addressing the consequences of Rule 4(a) (4) on our jurisdiction. A motion for voluntary dismissal pursuant to FRAP 42(b) will satisfy this requirement. [907331-1] DW [97-1070] [920531-1] Briefing is SUSPENDED pending further court order. (See order for further details) Jurisdictional memorandum due 2/19/97 for Cynthia Herdrich. (tim)
3/4/97	ORDER issued: The court is informed that counsel for the appellant did not receive a copy of the court's 2/6/97 jurisdictional order. Accordingly, the clerk of this court is directed to reissue that order. The appellant's jurisdictional memorandum is due 3/18/97. AM [97-1070] (elea)
3/18/97	Filed Appellant Cynthia Herdrich jurisdictional memorandum. [97-1070] [928587-1] (tim)
3/25/97	ORDER: Upon consideration of appellant's JURISDICTIONAL MEMORANDUM, IT IS ORDERED that briefing will proceed as follows: [928587-1] AM [97-1070] Appellant's brief due 4/23/97 for Cynthia Herdrich. Appellee's brief due 5/23/97 for Lori Pegram, for Carle Clinic Assoc, for Health Alliance. Appellant's reply brief due 6/6/97 for Cynthia Herdrich. (patb)
3/25/97	ORDER: Pursuant to FRAP 33, briefing will proceed as follows: [928587-1] SCO [97-1070] Appellant's brief due 5/5/97 for Cynthia Herdrich. Appellee's brief due 6/4/97 for Lori Pegram, for Carle Clinic Assoc, for Health Alliance Appellant's reply brief due 6/18/97 for Cynthia Herdrich. (patb)
4/3/97	ORDER: The court, on its own motion, is VACATING the briefing order of 3/25/97 setting a

DATE	PROCEEDINGS
	due date of 4/23/97 for the brief of the appellant. The court's order of 3/25/97 setting a due date of 5/5/97 for the filing of a brief by the appellant remains in effect. [907331-1] AM [97-1070] (elea)
4/8/97	ORDER: The court, on its own motion, is VACATING the briefing order of 3/25/97 which set the appellant's brief date as 4/23/97. Briefing shall proceed to the 3/25/97 order setting the appellant's due date as 5/5/97. [907331-1] AK [97-1070] (grac)
5/2/97	ORDER: Pursuant to F.R.A.P. 33, it is advised that the briefing schedule is modified as follows: [907331-1] DW [97-1070] Appellant's brief due 6/6/97 for Cynthia Herdrich. Appellees' brief due 7/7/97 for Lori Pegram, Carle Clinic Assoc and Health Alliance. Appellant's reply brief due 7/21/97 for Cynthia Herdrich. (nanc)
5/20/97	ORDER: Pursuant to F.R.A.P. 33, the briefing schedule is modified as follows: [928587-1] SCO [97-1070] Appellant's brief due 6/13/97 for Cynthia Herdrich. Appellees' brief due 7/14/97 for Lori Pegram, Carle Clinic Assoc and Health Alliance. Appellant's reply brief due 7/28/97 for Cynthia Herdrich. (nanc)
6/13/97	Brief deficiency letter sent to Appellant Cynthia Herdrich. [907331-1] [97-1070] (tyle)
6/13/97	Filed 15c appellant's brief by Cynthia Herdrich. Disk filed. [97-1070] [960879-1] (elea)
7/16/97	Filed 15c appellee's brief by Health Alliance, Carle Clinic Assoc, Lori Pegram. Disk filed. [97-1070] [971512-1] (dorh)
7/17/97	Filed motion by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram for damages, costs. [969469-1] and, for award of attorney's fees. [969469-2] [97-1070] (orac)

DATE	PROCEEDINGS
7/24/97	IT IS ORDERED that the following motion(s) and/or document(s) shall be taken with the case for determination by the merits panel: MOTION OF APPELLEES FOR DAMAGES, COSTS, AND FEES. The clerk will distribute these items and a copy of this order to the panel. [0-0] MAF [97-1070] (jenp)
7/28/97	Filed 15c appellant's reply brief by Cynthia Herdrich. Disk filed. [97-1070] [971508-1] (dorh)
10/17/97	ORDER: Argument set for Tuesday, December 2, 1997 at 9:30 a.m. Each side limited to 20 minutes. [97-1070] [997352-1] (broo)
10/27/97	Original record on appeal filed. Contents of record: 1 vol. pleadings; . [97-1070] [1000914-1] (odea)
11/13/97	ORDER: Argument reset for Tuesday, December 2, 1997 at 9:30 a.m. Each side limited to 15 minutes. [97-1070] [1006028-1] (broo)
12/2/97	Case heard and taken under advisement by panel: Circuit Judge Harlington Wood, Circuit Judge John L. Coffey, Circuit Judge Joel N. Flaum. [97-1070] [1012276-1] (broo)
12/2/97	Case argued by James P. Ginzkey for Appellant Cynthia Herdrich, Peter W. Brandt for Appellee Lori Pegram, Appellee Carle Clinic Assoc, Appellee Health Alliance [97-1070] [907331-1] (broo)
8/18/98	Filed opinion of the court by Judge Coffey. REVERSED and REMANDED for further proceedings. Circuit Judge Harlington Wood, Circuit Judge John L. Coffey, Circuit Judge Joel N. Flaum, dissenting. [97-1070] [907331-1] (orac)
8/18/98	ORDER: Final judgment filed per opinion. With costs: y. [97-1070] [1091772-1] (orac)

DATE	PROCEEDINGS
8/27/98	Filed Appellant Cynthia Herdrich Bill of Costs in the amount of \$433.26. [97-1070] [907331-1] (fran)
9/1/98	Filed 30c Petition for Rehearing with Suggestion for Rehearing Enbanc by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram. Dist. [97-1070] [1096386-1] (joc)
9/3/98	Sent clerk's copy of request to Appellant Cynthia Herdrich requesting 30c of their Answer to the Petition for Rehearing with Suggestion for Rehearing Enbanc filed by the Appellees on 9/1/98. [97-1070] [1096668-1] Answer to Petition for Enbanc Rehearing due 9/17/98 for Cynthia Herdrich. (jame)
9/3/98	Filed Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram objection to Appellant Cynthia Herdrich's bill of costs. [97-1070] [1097039-1] (joc)
9/11/98	Objection to amended bill of costs filed by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram. [97-1070] [907331-1] (joc)
9/17/98	Filed motion by Appellant Cynthia Herdrich to supplement her answer by inserting a certificate of interest, table of contents and table of cases and statutes. [1100733-1] 15c inserts tendered. [1100733-1] [97-1070] (joc)
9/21/98	ORDER issued DENYING motion to supplement. [1100733-1] AK [97-1070] Counsel shall rebind the Answer to the Petition to contain all the proper items and refile by 9/22/98 for Cynthia Herdrich. (heid)
9/21/98	Filed 30c Answer of Appellant Cynthia Herdrich to Petition for Rehearing with Suggestion for Rehearing Enbanc. Dist. [97-1070] [1101640-1] (joc)

DATE	PROCEEDINGS
9/25/98	ORDER issued DENYING as MOOT the objections to the bill of costs and amended bill of costs. [1097039-1] NM [97-1070] (joc)
12/7/98	ORDER: Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram Petition for Rehearing with Suggestion for Rehearing Enbanc is DENIED. A vote for the active members of the Court was requested. A majority did not favor rehearing en banc. Chief Judge Posner and Circuit Judges Flaum, Easterbrook, and Diane P. Wood voted to grant rehearing en banc. A majority of the judges on the original panel voted to deny rehearing en banc. [97-1070] [1096386-1] (joc)
12/8/98	ORDER: The court, on its own motion, hereby WITHDRAWS the order of 12/7/98, in the case Herdrich V. Pegram. [97-1070] (heid)
12/14/98	Certificate of interest filed by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram. [97-1070] [907331-1] (joc)
12/14/98	Terminated attorney Peter W. Brandt for Lori Pegram, attorney Peter W. Brandt for Carle Clinic Assoc, attorney Peter W. Brandt for Health Alliance and added attorney Richard D. Raskin per appearance form. Appearance form filed for Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram by attorney Richard O. Raskin. [97-1070] [907331-1] (joc)
12/15/98	MANDATE ISSUED WITH BILL OF COSTS IN THE AMOUNT OF \$433.26. [97-1070] [907331-1] (cove)
12/18/98	ORDER issued. The mandate in this cause is VACATED, erroneously issued. [97-1070] [907331-1] (joc)
12/22/98	Filed mandate receipt. [97-1070] [1131138-1] (tina)

DATE	PROCEEDINGS
1/5/99	ORDER: The court, on its own motion [sic], VACATES the mandate and Bill of Costs of 12/15/98 as erroneously issued. [97-1070] [907331-1] (hard)
2/1/99	Original record on appeal filed. Contents of record: 1 vol. pleadings; . [97-1070] [1143117-1] (odea)
3/5/99	Filed motion by Appellant Cynthia Herdrich to expedite ruling on defendants/appellees motion to reconsider. [1154961-1] [97-1070] (squi)
3/8/99	Opinion filed DENYING Appellees Health Alliance, Carle Clinic Assoc, and Lori Pegram's Petition for Rehearing with Suggestion for Rehearing Enbanc. Enbanc, Circuit Judge Frank H. Easterbrook, with whom Chief Judge Richard A. Posner, and Circuit Judges Joel N. Flaum and Diane P. Wood, join, dissenting from the denial of rehearing en banc. [97-1070] [1096386-1] (jame)
3/16/99	MANDATE ISSUED AND ENTIRE RECORD RETURNED. (Contents returned: 1 vol. pleadings;.) [97-1070] [928587-1] (cove)
3/19/99	Filed mandate receipt. [97-1070] [1159114-1] (tina)
4/8/99	ORDER issued DENYING as MOOT the motion to expedite ruling. On 3/8/99, this court denied the Petition for Rehearing and Suggestion for Rehearing En Banc. [1154961-1]NM[97-1070] (joce)
6/11/99	Filed notice from the Supreme Court of the filing of a Petition for Writ of Certiorari. Supreme Court Case No.: 98-1949. [97-1070] [1187445-1] (kell)
10/1/99	Filed order from the Supreme Court GRANTING the Petition for Writ of Certiorari. Supreme Court Case No.: 98-1949. [97-1070] [1220172-1] (squi)

**GROUP MEDICAL HEALTH PLAN
SUMMARY PLAN DESCRIPTION
01-01-91**

**SUMMARY PLAN DESCRIPTION OF
THE EMPLOYEES AND AGENCY MANAGERS
GROUP MEDICAL HEALTH PLAN**

Section I of the Group Medical Health Plan description applies to the Health Maintenance Organizations (HMO) option and to the Group Medical Insurance option.

Section II provides information exclusive to the Group Medical Insurance option.

Section III and the Appendix provides information exclusive to the HMO option.

TABLE OF CONTENTS

SECTION I INFORMATION THAT APPLIES TO GROUP MEDICAL INSURANCE AND HMOs

Notice Regarding Continuation of Coverage
 Extension of Certain Benefits Upon Termination Coverage
 Rights and Protections Under ERISA
 Who Runs the Plan
 Additional Information
 Eligibility, Enrollment and Effective Date
 Employees
 Dependents
 Change in Marital or Dependent Status

SECTION II GROUP MEDICAL INSURANCE OPTION

Certificate of Coverage
 Comprehensive Medical Provisions
 Deductible
 Coinsurance
 Benefit Period
 Maximum Benefit
 Premiums Shared
 Pre-Existing Conditions
 Definitions/Schedule of Benefits/Ineligible Charges
 Acupuncture (Exc)
 Alcohol/Drug Tx Facility
 Ambulance Services and Other Transport Services
 (Benefit)
 Anesthesia (Benefit)
 Artificial Insemination (Exc)
 Breast Implants (Benefit)

Exc=Exclusion

Def=Definition

Cardiac Rehab (Exc)
 Christian Science (Benefits)
 Cosmetic (Def)
 Cosmetic (Exc)
 Cosmetic Surgery (Benefits)
 Coverage Not in Force
 Custodial Care (Def)
 Custodial Care (Exc)
 Dental Coverage (Benefit)
 Dental (Exc)
 Dependents (Def)
 Developmental Disorders (Def)
 Developmental/Learning Disorders (Exc)
 Diabetic Instruction (Benefit)
 Diagnostic Testing (Benefit)
 Diet/Wt. Loss (Exc)
 Disability (Def)
 Drug/Medicine — Unapproved (Exc)
 Durable Medical Equipment (Def)
 Educational Training (Exc)
 Eligible Charges (Def)
 Eyeglasses/Contact Lens (Exc)
 Governmental Agency (Exc)
 Hearing Aid (Exc)
 Home Health Care (Benefits)
 Home Health Care (Def)
 Hospice (Benefits)
 Hospice (Def)
 Hospital (Def)
 Hospital Supplies (Benefits)
 Household Medical Provider (Exc)
 Illness (Def)
 Investigational/Experimental Coverage (Benefits)

Exc=Exclusion

Def=Definition

Legal Obligation (Exc)
 Maintenance Therapy
 Maximum Benefit
 Mental/Nervous (Def)
 Mental/Nervous (Benefits)
 Military (Exc)
 Modifications (Exc)
 National Scientific Organizations (Def)
 Necessary Treatment (Def)
 Necessary Treatment (Exc)
 Organ Donor (Benefit)
 Outpatient Prescription Drug Expense Benefit
 Partial Hospitalization (Ben)
 Partial Hospitalization (Def)
 Physician (Def)
 Physician's Direct Care (Exc)
 Physician's Fee (Benefit)
 Physiotherapist (Benefits)
 Pre-Existing Illness (Def)
 Pre-Existing Illness (Exc)
 Pre-Existing Illness Guidelines
 Preventive Care (Benefit)
 Private Duty Nursing (Benefit)
 Proof of Loss
 Radial Keratotomy (Exc)
 Radiation Therapy (Benefit)
 Reasonable and Customary (Def)
 Reasonable and Customary (Exc)
 Rehab Facility (Def)
 Rehab Facility Supplies (Benefit)
 Related Physician (Exc)
 Respite Care (Def)
 Room and Board Charges (Def)

Exc=Exclusion
 Def=Definition

Routine Preventive Care (Exc)
 Second Surgical Opinion (Benefit)
 Skilled Nursing Facility (Def)
 Skilled Nursing Facility (Benefit)
 Smoking Program (Exc)
 Speech Therapy (Benefit)
 Sterilization Reversal (Exc)
 Subluxation/Misalignment (Benefit)
 Thermography (Exc)
 TMJ (Benefit)
 Total Disability/Totally Disabled (Def)
 Utilization Review
 Visit (Def)
 War Exclusion
 Well Baby Care (Benefit)
 Workers Compensation (Exc)
 Extension of Comprehensive Medical Coverage
 Coordination of Benefits
 Examples Showing How The Comprehensive Medical
 Plan Works
 Medical Records to Substantiate Claims
 Termination of Insurance
 Conversion
 Preferred Provider Organization (PPO)
 General Information
 How to File a Claim
 Processing Claims
 Payment of Claim
 Denial of Claim
 Review Procedure

SECTION III Health Maintenance Organization Option

General Information

Exc=Exclusion
 Def=Definition

How To Obtain HMO Information
 Termination of Benefits
 Premium Shared
 Detailed Information On HMOs Offered in Your Area

Exc=Exclusion
 Def=Definition

NOTICE REGARDING CONTINUATION OF GROUP MEDICAL INSURANCE/HMO COVERAGE

As of January 1, 1987, if you are enrolled in a health care plan and your coverage terminates, you may be able to arrange to continue the coverage. The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to offer continuation of health coverage to individuals willing to pay the entire premium. The plans affected by this Act are: State Farm Group Medical Health Plan (Group Medical Insurance and Health Maintenance Organizations-HMOs.), State Farm Group Dental, and the Medical Expense Reimbursement Plan (MER).

The chart below lists the reasons (qualifying events) for loss of coverage and the length of time coverage can be extended.

Individual Covered	Reasons for Loss of Coverage	Continued For
EMPLOYEE (and covered dependents)	Termination for any reason other than gross misconduct Reduction of work hours	18 Months
SPOUSE (and covered dependents)	Death of employee, divorce or legal separation from employee, or employee's eligibility for Medicare	36 Months
DEPENDENT	Individual ceases to be a dependent under the terms of the plan	36 Months

Election of continuation must be made within 60 days of loss of coverage as described above.

Since the company has no way of knowing when a member divorces, legally separates or a child becomes ineligible for coverage; it is your responsibility to notify the Personnel Department and request continuation of coverage within 60 days of the event causing the loss of coverage and/or 60 days

from the date coverage ceases. Once you've notified the Personnel Department of your request, the continuation election and premium payment procedures will be provided.

If you choose to continue your coverage, it will continue until the earlier of any one of the following events:

1. The end of the number of months on the chart above (or, if you, the State Farm Associate are disabled at the time of your termination or reduction in hours, you may receive up to 29 months).
2. The premium for the continued coverage is not paid on or before the due date.
3. The covered person becomes eligible for Medicare (however, if you, the State Farm Associate, become entitled to Medicare while under continuation coverage, your eligible dependents may be entitled to an additional 36 months of continuation coverage).
4. The covered person becomes covered under another group health plan (unless that plan contains a pre-existing exclusion or limitation that would specifically limit coverage for any pre-existing condition that you or any eligible dependent may have).
5. State Farm terminates all of its group health plans.

NOTE: If a former spouse or surviving spouse of a State Farm employee, agency manager or trainee agent is age 55 at the time of the event causing the loss of active coverage, he/she may participate in continuation coverage until the earlier of the following:

1. His/her entitlement to Medicare or attainment of the qualifying age for Medicare.
2. The premium for the continued coverage is not paid on or before the due date.

3. He/she remarries (this alone will not terminate the continuation coverage until after the original 36 months)
4. He/she becomes covered under other employer group insurance.

EXTENSION OF CERTAIN BENEFITS UPON TERMINATION OF INSURANCE

1. In the event of an insured retired employee's death, his or her spouse may continue to be covered.
2. Coverage may be provided for the spouse of an employee who dies prior to retirement if the employee was participating in the group medical plan and had at least 5 years of credited service on the employee's Retirement Plan and whose age plus years of credited service equalled 55 on the date of death.

With respect to items 1. and 2. above, during any period that either the retired employee or spouse is insured, the retired employee's never married children, as defined on page 4100, may also be insured provided the never married children are dependent upon the surviving spouse for a majority of their support.

3. If on the date of termination of this Policy an insured individual is totally disabled by an illness, coverage will be extended during the subsequent period of continuous total disability but for no longer than 12 months [sic] after the date the Policy terminates. Coverage will be extended solely for illness(es) incurred prior to the termination of this Policy.
4. When an employee's insurance under this Policy terminates because of termination of employment or membership within the eligible classes for benefits under this Policy, the employee may be entitled to have his/her

coverage and dependents' coverage continued under this Policy.

Illinois law provides:

- a. The employee must have been continuously insured for at least three months under this Policy.
- b. This election must be made within the ten-day period following the later of:
 - i. the date of termination of insurance, or
 - ii. the date the employee is given written notice of the right of continuation,
 but in no event later than 60 days after the date of termination of insurance.
- c. Premiums be paid on a monthly basis in advance to State Farm. Coverage may be continued until the earliest of the following dates:
 - i. the date 9 months after the termination of coverage;
 - ii. the date the employee becomes eligible for Medicare;
 - iii. the end of the period for which premium was paid if the employee fails to make the advance premium payment;
 - iv. the date the employee becomes eligible for coverage under any other group insured or uninsured hospital, surgical or medical expense plan;
 - v. the date this group Policy is terminated; or
 - vi. the date the employee elects to exercise the conversion privilege.

- d. Continuation will not be available for any employee who was discharged because of the commission of a felony in connection with his/her work, or because of theft in connection with his/her work, for which the employer was in no way responsible; provided the employee admitted his/her commission of the felony or theft or such act has resulted in a conviction or order of supervision.
5. In the event of an insured employee's death or divorce from an insured Employee, the former covered spouse is entitled to have his/her coverage and dependents' coverage continued under this Policy, provided such spouse complies with the conditions stated below. Failure by the former spouse to comply with these conditions terminates the right to continue coverage.
- a. The spouse must provide written notice to the Personnel Department of dissolution of marriage or death within 30 days of the divorce or death of the employee.
 - b. Upon receipt of this notice, the Personnel Department will provide the former spouse with an election form which describes the amount of premium and method and place of payment.
 - c. The election forms must be returned fully completed by certified mail, return receipt requested, within 30 days after the receipt of the forms by the former spouse.

If you have any questions about continuation coverage, please contact the Plan Administrator, Group Medical Continuation, Corporate Benefits and Services, State Farm Insurance, One State Farm Plaza, Bloomington, IL 61710-0001.

JAMES E. RUTROUGH

VICE PRESIDENT-PERSONNEL

MEMBER RIGHTS AND PROTECTIONS UNDER ERISA:

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans such as the plan described in this booklet. As in the past, the Company fully intends to support your rights. Nevertheless, federal law and regulations require that a statement of ERISA rights be included in this description of your plan.

As a participant in the Group Medical Health Plan, you have the following rights:

You may examine, without charge, all plan documents—including any insurance contracts, annual reports, plan descriptions, and other documents filed with the Department of Labor. All documents are available for review by you or your Dependents in the General Personnel Department, Corporate Headquarters, and Regional Personnel Departments during normal business hours.

If you want a personal copy of plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of reproduction of these copies.

Under ERISA, the people responsible for operating the plan are called fiduciaries. These individuals have an obligation to administer the plan prudently and to act in the interest of plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. In case

of claim denial—in whole or in part—you will receive a written explanation of the reasons for the denial. Then, if you wish, you may request the administrator to review and reconsider your claim.

If you feel that your ERISA rights have been violated, you may file suit. Among the violations for which you may file suit are:

Improper denial of benefits.

Misuse of plan funds by a fiduciary or discrimination against you for asserting your rights. In either case, you may seek assistance from the Labor Department or file suit in a federal court.

Failure of the Plan Administrator to provide material within 30 days after receiving your written request—unless due to reasons beyond the administrator's control. If a violation exists, the court may require the Plan Administrator to provide the materials and to pay you up to \$100 for each day's delay.

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you sued to pay these costs and fees. If you lose—or if the court finds your suit to be frivolous—you may be ordered to pay these costs and fees.

If you have any questions about your plan, please contact your supervisor or a representative of the Personnel Department. For questions regarding this explanation of your rights under ERISA, contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

WHO RUNS THE PLAN:

This plan was established and is maintained by the State Farm Mutual Automobile Insurance Company, One State

Farm Plaza, Bloomington, Illinois 61710, telephone number (309) 766-6848. In addition to the State Farm Mutual Automobile Insurance Company, the following affiliated companies also participate:

1. State Farm Life Insurance Company
2. State Farm Life and Accident Assurance Company
3. State Farm Fire and Casualty Company
4. State Farm County Mutual Insurance Company of Texas
5. State Farm General Insurance Company

This comprehensive medical plan is administered by the Plan Administrator in accordance with the applicable contracts in force under the Group Medical health plan. The State Farm Mutual Automobile Insurance Company has been designated as the Plan Administrator. James E. Rutrough, Vice President-Personnel, has been designated as agent for service of legal process. NOTE: Service of legal process may also be made upon the Plan Administrator.

The Plan Administrator shall have the power to make all reasonable rules and regulations required in the administration of the Plan and for the conduct of its affairs, to make all determinations that the Plan requires for its administration, and to construe and interpret the Plan whenever necessary to carry out its intent and purpose and to facilitate its administration. All such rules, regulations, determinations, constructions and interpretations made by the Plan Administrator shall be binding upon the Companies, all Employees, Agency Managers, Trainee Agents and their Dependents and all other interested parties.

ADDITIONAL INFORMATION:

On the preceding pages we have tried to describe the Group Medical Health Plan in easy-to-understand terms. But, if this Summary Plan Description contains any statements that disagree with the Group insurance contract or the HMO contract, the respective contracts shall govern.

In addition to the material in this Summary Plan Description, State Farm Insurance Companies file two reports with the United States Department of Labor. One is a description of the Plan called the EBS-1 Form and the other is an annual financial report. The plan description, the annual report, and any legal documents are available for review by you or your Dependents in:

1. The General Personnel Department, Corporate Headquarters, and
2. Regional Personnel Departments,

during normal business hours. Upon written request to the Personnel Department of the Regional Office or the General Personnel Group Insurance Division, State Farm Insurance Companies, Corporate Headquarters, One State Farm Plaza, Bloomington, Illinois, 61710, copies of any or all of the documents will be furnished to you at a reasonable charge. The Plan's records are maintained on a calendar year basis, ending on December 31.

For purposes of identification, the number 501 has been assigned to this comprehensive medical plan. The Internal Revenue Service has assigned State Farm Mutual Automobile Insurance Company the employer identification number 37-0533100. When writing about this plan, please identify it both by name and by the above two numbers.

State Farm Mutual Automobile Insurance Company is the underwriter for all of our plans providing medical services to State Farm associates who desire to participate in these plans by showing evidence of insurability.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE:

EMPLOYEES:

Employees who customarily work 25 hours or more a week and customarily work seven months or more a year, agency managers and trainee agents, hereinafter called "Employees," who are hired on the first day or first workday of the month are eligible on the date they are hired. Employees hired after the first workday of the month are eligible on the first day of the following month. If an Employee and spouse are both eligible for either Insurance Plan (Agents or Employees) or HMO option, either or both may be covered as an Employee/member. If either chooses not to be covered as an Employee/member, he or she may be covered as a Dependent of his/her spouse, provided the spouse is covered as an Employee/member.

- a. If you apply on time, the only requirement for enrollment and consideration for coverage is the completion of an individual enrollment card. If you are hired on the first day or the first workday of the month and you enroll within your first five workdays, your coverage is effective on your date of hire. If you are hired after the first workday of the month and enroll within the month you are hired, your coverage will be effective on the first day of the month following the month in which you are hired.
- b. If you do not enroll within the time limits set forth above but do enroll within 31 days of the date you are hired no medical evidence of insurability is required

and your coverage will be effective on the first day of the calendar month coincident with or next following the date you enroll.

- c. IF YOU DO NOT ENROLL WITHIN 31 DAYS OF THE DATE YOU ARE HIRED, SATISFACTORY EVIDENCE OF INSURABILITY IS REQUIRED FOR YOURSELF AND EACH OF YOUR DEPENDENTS. Evidence of insurability in each case will require that the Employee completes a Declaration of Insurability form for each person to be covered. Additional medical records and/or a medical examination may be requested which must be provided at the applicant's expense. Coverage becomes effective on the first day of the calendar month coincident with or next following approval by the State Farm Mutual Automobile Insurance Company of such evidence of insurability.
- d. If you waived or cancelled coverage under this Health Plan to enroll in coverage provided by another employer and lose eligibility for that coverage due to reasons other than Illness, you may be eligible for coverage under this Policy. Application must be made within 31 days of loss of eligibility under the other employer's plan or evidence of insurability will be required. All other requirements specified in this Policy must be met.
- e. If you previously waived or cancelled coverage and are reassociated with State Farm within one year of your termination date you must provide evidence of insurability.

For a, b, c, d, and e above, if you are not actively at work on the date your coverage would become effective, coverage shall not become effective for you and any Dependents until the next following day on which you are

actively at work. If you and/or your Dependent(s) must furnish satisfactory evidence of insurability as a condition of becoming covered under this Health Plan and termination of membership within the eligible classes occurs without such evidence being furnished, you and/or your Dependent(s) shall continue to be subject to this requirement if you again become eligible for group medical coverage under this Health Plan or Master Policy HG00004.

Evidence of insurability is required for Employees and their Dependent(s) who previously waived or cancelled coverage offered or provided under this Health Plan or Master Policy HG00004.

Employees of agents, agency managers, and trainee agents will not be considered Employees for purposes of this definition and will not be included for coverage under this Policy.

DEPENDENTS:

Dependent means:

- a. an Employee's spouse, or
- b. an Employee's never married child until the end of the calendar year in which the child attains 23 years of age or the end of the calendar year in which the child becomes an Employee or agent, provided that over one-half of the child's annual support is provided by the Employee (or, in the case of a child of a divorced Employee, over one-half of the child's support is provided by his/her parents), or
- c. an Employee's never married
 - i. stepchild (as long as the natural parent is covered under the plan) residing with the Employee more than six months of a calendar year

- ii. foster child residing 365 days per year with the Employee who is the court appointed legal guardian and who claims the child as a dependent for federal income tax purposes, or
- iii. a legally adopted child (Note: a child who is in the custody of the Employee, pursuant to a petition for adoption filed with a court of competent jurisdiction)

until the end of the calendar year in which the child attains 23 years of age or the end of the calendar year in which the child becomes an Employee or Member, provided that over one-half of the child's annual support is provided by the Employee (or, in the case of a child of a divorced Employee, over one-half of the child's support is provided by his/her parents), or

- d. an Employee's never married child who has attained age 23 while the child is
 - i. mentally or physically incapable of earning his/her own living,
 - ii. actually receiving over one-half of his/her annual support from the Employee (or, in the case of a child of a divorced Employee, receiving over one-half of his/her support from his/her parents), and
 - iii. covered hereunder on the date immediately preceding the day insurance otherwise would have been terminated due to age.

Eligibility:

- a. If you have one or more Dependents when you become eligible for participation in this Health Plan and you enroll yourself and Dependents on or prior to

this date, your Dependents will be covered when your coverage becomes effective,

- b. If you do not enroll your Dependents when you become eligible for participation in this Health Plan but do so within 31 days of that date, your Dependents will become covered on the first day of the calendar month coincident with or next following the date of your application for Dependent coverage.
- c. If you fail to enroll your Dependents within 31 days of the date you first become eligible for Dependents' coverage, evidence of insurability will be required and coverage will not become effective until the first day of the calendar month coincident with or next following approval of such evidence of insurability.
- d. If your Dependents for whom coverage was waived or cancelled under this Health Plan enroll in coverage provided by another employer and later lose eligibility for this coverage due to reasons other than illness, they may be eligible for coverage under this Health Plan if you are covered under this Health Plan. Application must be made within 31 days of loss of eligibility under the other employer's plan or evidence of insurability will be required. All other requirements specified in this Policy must be met.
- e. If you previously waived or cancelled coverage and are reassociated with State Farm within one year of your employment termination date, your dependents must provide evidence of insurability.

Once you are enrolled for Dependents' coverage, newly acquired Dependents will be covered on the date acquired if written notification is provided and any required premium is paid.

If you are not enrolled for Dependents' coverage, newly acquired Dependents will be covered on the date acquired if written notification is provided within 31 days of the date acquired and any required premium is paid.

If your Dependent is confined in a Hospital on the date you otherwise become covered for Dependents' coverage with respect to such Dependent, that Dependent will not become covered until the day following the Dependent's final discharge from the Hospital.

Written notice to the Personnel Department is required to cover a Dependent subsequent to your effective date.

Dependent children are eligible for coverage under only one option whether under an HMO or Master Policy HG00003 or Master Policy HG00004. A Dependent child cannot be covered concurrently by more than one Employee under this policy.

Note: Any person covered as an Insured or Insured Dependent under Master Policy HG00004 is not eligible simultaneously for coverage in either capacity under Master Policy HG00003 or an HMO.

CHANGE IN MARITAL OR DEPENDENT STATUS

Regardless of the medical option you have chosen, if a change should occur in your marital status or dependent status, be sure to notify your supervisor and Group Insurance Specialist.

SECTION II - GROUP MEDICAL INSURANCE

CERTIFICATE OF COVERAGE

THE STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY (hereafter called the Insurer), Bloomington, Illinois, hereby certifies that the holder of this

certificate is insured under and subject to the terms and conditions contained in Master Policy No. HG00003 issued to:

**STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY
and its Subsidiaries and Affiliates**

(hereafter called the Policyholder) while he/she is within the classes eligible for insurance thereunder provided application has been made and accepted and that the necessary contributions are made toward premiums for such insurance.

COMPREHENSIVE MEDICAL PROVISIONS:

Comprehensive Medical Expense Benefits provide payment of Eligible Charges up to a maximum as shown below:

MAXIMUM BENEFIT:

Classification	Maximum
All Eligible Employees	1,000,000
Their Dependents	1,000,000

Note:

- (1) The Comprehensive Medical Maximum was increased from \$250,000 to \$ 1,000,000 effective January 1, 1983. However, the increased maximum did not apply to any insured individual who was hospital confined on January 1, 1983 and will not apply to such person unless and until he/she is finally discharged from hospitalization.
- (2) As of January 1, 1983, the remaining Maximum Benefit is \$1,000,000 reduced by the amount of benefits paid, if any, under Master Policies G-5989 and G-637A.

DEDUCTIBLE:

The individual deductible applies to the Eligible Charges of each calendar year, but it only applies once for you, and only once for each Dependent, in any calendar year regardless of the number of illnesses. However, when members of a family have incurred Eligible Charges that satisfy the family deductible amount during a calendar year, no further deductible is required in connection with any member of that family.

The deductible applies to all Illness charges, including inpatient nursery charges for well-baby care of a newborn infant. The deductible does not apply to eligible preventative diagnostic tests and procedures as outlined in Benefit #28. (See page 4290)

The deductible amounts are as follows:

- Plan A — \$100 individual/\$300 family
- Plan B — \$250 individual/\$500 family
- Plan C — \$500 individual/\$1000 family

COINSURANCE:

After satisfying the Deductible, Comprehensive Medical Expense Benefits provide payment as follows:

(a) Individual

- Option A — 80% of the first \$2000 of Eligible Charges
- Option B — 80% of the first \$5000 of Eligible Charges
- Option C — 75% of the first \$8000 of Eligible Charges

Family

Option A — 80% of the first \$2,000 of Eligible Charges for each insured Individual

Option B — 80% of the first \$10,000 of Eligible Charges

Option C — 75% of the first \$16,000 of Eligible Charges

- (b) 100% of the first \$40 of each charge for treatment of Mental or Nervous Disorders or psychoanalytic care, rendered other than while the patient is confined to a Hospital as a registered bed patient, subject to the other limitations herein. (see page 4215.)
- (c) 100% of the first \$20 of each charge for certain types of care of distortions, misalignment or subluxation of, or in the vertebral column unless such services are rendered during general anesthesia, during a cutting operation or while the patient is confined in a Hospital. (see page 4220).
- (d) 100% of the first \$40 per Visit (maximum of five Visits) for bereavement counseling rendered as part of a Hospice care program (see page 4270).
- (e) 100% of the charges for a second (and third) surgical opinion and associated ancillary diagnostic services performed by a Board Certified Specialist other than the Physician who recommended the surgery.
- (f) 100% of the first \$50 per Home Health Care Visit subject to a maximum payment of \$5,000 per calendar year (see page 4260).
- (g) After satisfaction of the co-payment amount in (a) above or a combination of (a) through (f) above, in any calendar year, any subsequent eligible charges

incurred in such calendar year are payable at 100% except as noted in (h) below.

- (h) Charges for the care or treatment of alcohol abuse, drug abuse, or Mental or Nervous Disorders are payable at 80% for Options A & B and 75% for Option C except that certain charges for outpatient care of mental or nervous conditions are payable at 100% as set forth in items (b) and (d) above.

BENEFIT PERIOD:

A Benefit Period is a calendar year or that portion of a calendar year during which you or your Dependent is insured under this Master Policy. All Eligible Charges incurred during a Benefit Period for all Illnesses are used in computing benefit payments.

A Benefit Period terminates on the last day of the calendar year, the last day of the month in which you or your Dependent otherwise ceases to be eligible for insurance, or the day the Maximum Benefit is reached, whichever occurs first.

Calendar years shall begin on January 1 and end on December 31 of the same year.

MAXIMUM BENEFIT:

The maximum benefit is a lifetime aggregate payment for all Illnesses. However, a person who has received payment for all or a part of the maximum benefit may be reinstated for the full maximum benefit upon approval of evidence of insurability satisfactory to the Insurer.

On January 1 of every year, the balance of your (or your Dependent's) maximum benefit remaining shall be automatically increased \$2,500 without evidence of insurability or the amount necessary to bring that balance

to the full maximum benefit, whichever is the lesser amount.

PREMIUMS SHARED:

The premiums for this insurance are shared by the Employee and the Policyholder. Your share of the premium may be paid with pre-tax (Flexible Compensation) dollars according to the terms of the State Farm Insurance Companies Flexible Compensation Plan for U.S. Employees, or with after-tax dollars deducted from your paycheck.

The premium charged for this Master Policy is essentially the cost of benefits provided plus the cost of administration. Nevertheless, depending upon underwriting results from year to year, the premium charged may result in income to the Insurer. If in any calendar year the aggregate income to the Insurer as a result of this Master Policy is in excess of the Policyholder's share of the aggregate cost, an amount equal to such excess shall be applied by the Policyholder for the sole benefit of the Employees.

PLEASE NOTE:

This certificate is a brief description of your coverage—all terms and conditions governing your coverage are contained in the Master Policy issued to your employer—you are covered if you are eligible, have properly enrolled in the plan, and are making your necessary payments toward the premium.

The Master Policy may be amended or altered at any time by written agreement between the Policyholder and Insurer without your or your Dependents' consent.

If you or your Dependents leave the plan for any reason while continuing to be eligible, reenrollment at a later

date will be subject to satisfactory medical evidence of insurability and coverage may be denied.

If you have questions about the coverage for which you are eligible or the benefits provided, contact your supervisor or the Group Insurance Benefits Specialist.

DEFINITIONS:

The following words and phrases shall have the stated meanings when used in these provisions for Comprehensive Medical Expense Benefits. Additional terms are defined in the Master Policy which is available for review by request to the Personnel Department.

COSMETIC SURGERY:

The surgical alteration of tissue for the improvement of the insured individual's appearance rather than improvement or restoration of bodily function.

CUSTODIAL CARE:

Those services for personal, family or domestic needs that are primarily designed to assist with the activities of daily living. This care could be provided by persons without professional skills or training. Custodial care includes, but is not limited to, help in walking, assistance with bathing, dressing, and eating.

DEVELOPMENTAL DISORDERS:

Developmental Disorders mean disorders that are characterized by or whose manifestations include delays in development of specific academic, language, speech and motor skills but are not due to specific, identifiable, physical or neurological disorders.

DURABLE MEDICAL EQUIPMENT:

Equipment which

- a. can withstand repeated use,
- b. is primarily and customarily used to serve a medical purpose,
- c. generally is not useful to a person in the absence of Illness, and
- d. is appropriate for use in the home.

ELIGIBLE CHARGES:

Those charges incurred by an insured individual

- a. as a result of an Illness for which the insured individual is not entitled to benefits under any Workers' Compensation or Occupational Disease law,
- b. which are Necessary Treatment of an illness,
- c. are not in excess of the Reasonable and Customary Charge for the services performed or the materials furnished, and
- d. with respect to Medicare participants, are not in excess of the balance billing limit for charges allowed by Medicare on physician fees incurred by Medicare participants.

HOME HEALTH CARE:

A formal program of part-time or intermittent care and treatment for an Illness which is performed in the home of an insured individual. It must be provided by a Hospital or home health service or agency and must:

- a. be established and operated in accordance with the applicable laws in the jurisdiction in which it is

located and, where licensing is required, be licensed and approved by the regulatory authority having responsibility for licensing under the law,

- b. be under the direct supervision of a Physician,
- c. be coordinated by a graduate registered nurse (R.N.), and
- d. maintain medical records on each patient.

HOSPICE:

An agency that provides a coordinated program of home and inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. A terminally ill person is one who has been diagnosed by a Physician as having a life expectancy of six months or less. The hospice agency must:

- a. be established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, be licensed and approved by the regulatory authority having responsibility for licensing under the law,
- b. be under the direct supervision of a Physician,
- c. be coordinated by a graduate registered nurse (R.N.),
- d. provide continuous 24-hour nursing service, and
- e. maintain medical records on each patient.

HOSPITAL:

Hospital means a legally operated institution having accommodations for the care and treatment of sick or injured resident inpatients which is:

- a. licensed as a hospital under the Hospital Licensing Laws of the state in which it is situated; or

- b. accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

This definition shall not include any institution operating as a clinic, nursing home, rest home, home for the aged, convalescent home, group home, half-way house, residential treatment facility or similar establishment.

ILLNESS:

A bodily disorder or disease, Mental or Nervous Disorder, pregnancy or accidental bodily injury. In addition, charges for well-baby nursery care will be considered on the same basis as charges incurred in connection with an "illness." With respect to the transplant of a natural organ or organs or other natural tissue from one living person to another, the medical expense of the donor will be considered as Eligible Charges for an illness of the donor.

MENTAL OR NERVOUS DISORDER:

Mental or Nervous Disorder means a neurosis, psychoneurosis, psychopathy, psychosis or other mental, behavioral, or emotional disease, disturbance, or disorder of any kind regardless of the cause or origin, including, but not limited to autism and affective mood disorders.

NATIONAL SCIENTIFIC ORGANIZATION:

An entity composed of medical specialists recognized by the American Medical Association or the Council on Medical Specialty Societies that evaluate diagnostic and therapeutic procedures to determine whether such procedures are clinically acceptable.

NECESSARY TREATMENT:

The treatment.

- a. must be recommended by a Physician;

- b. must be commonly and customarily recognized throughout the Physician's profession and within the United States as appropriate in the treatment of the patient's diagnosed Illness; and
- c. determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed Illness.

In the case of Hospital confinement, on an inpatient or outpatient basis, the length of confinement and medical services and supplies furnished by the Hospital will be considered "necessary treatment" only to the extent they are determined by the Insurer to be related to the treatment of the diagnosed Illness.

PARTIAL HOSPITAL PROGRAM

A program which provides an integrated and comprehensive schedule of recognized psychiatric treatment under the direct supervision of a Physician. The "partial hospitalization program" must be:

- a. part of a Hospital complex, a component of a community mental health center, or a "free-standing" unit and
- b. established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, be licensed and approved by the regulatory authority having responsibility for licensing under the law.

PHYSICIAN:

A licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which these services are performed.

PRE-EXISTING ILLNESS(ES):

An Illness for which medical advice or treatment was recommended by, received from or diagnosed by a Physician within 3 months prior to the effective date of coverage of the insured individual.

REASONABLE AND CUSTOMARY CHARGE:

Reasonable and Customary Charge means, with respect to fees charged by a Physician or by a provider of professional services, medicines, or supplies, the most common charge, in the absence of insurance, for similar professional services, medicines, or supplies within the geographic area where the service, medicine, or supply was actually provided, so long as that charge is reasonable. Geographic area means the municipality (or, in the case of a large city, the subdivision thereof) in which the service, medicine, or supply is actually provided or a greater area if necessary to obtain a representative cross-section of charges for a similar service, medicine, or supply. Reasonable and customary charges will be determined, in good faith, by the Insurer.

In determining whether a charge is reasonable and customary, one or more of the following factors may be considered:

- a. the level of skill, extent of training, and experience required to perform the procedure or service;
- b. the length of time required to perform the procedure or service as compared to the length of time required to perform other similar procedures or services;
- c. the severity or nature of the illness or injury being treated;
- d. the cost to the provider of providing the service or performing the procedure;

- e. the cost and availability of alternative modes of treatment; and
- f. such other factors, in the reasonable exercise of discretion, which are determined to be appropriate.

The following limits apply to multiple surgical operations:

- a. When multiple or bilateral procedures, which add significant time or complexity to patient care, are performed at the same operative session, the maximum limit for the procedures shall be the Reasonable and Customary Charge for the primary procedure plus 50% of the Reasonable and Customary Charge for the secondary procedure.
- b. When an incidental procedure (e.g. incidental appendectomy, lysis of adhesions, excision of previous scar) is performed at the same operative session, the Reasonable and Customary Charge will be that of the primary procedure only.
- c. When an inherent procedure is performed at the same operative session, the Reasonable and Customary Charge will be that of the primary procedure only.

REASONABLE AND CUSTOMARY CHARGE EXAMPLES

The Group Medical Plan provides coverage for eligible procedures up to an amount that is considered reasonable and customary (R&C). State Farm uses data gathered every six months representing the actual fees charged by medical providers for specific procedures. Since charges for the same procedure may vary by area of the country, we use data from the specific geographic location where the procedure is performed. This statistical data is ranked into percentiles. State Farm uses the 90th percentile

amount which means that 90% of the reported charges are at or below this amount. In addition, State Farm adds a 5% administrative allowance to this figure. (See page 4180 for definition of Reasonable and Customary.)

EXAMPLE 1:

Let's look at removal of a gallbladder performed in the Waco, Texas area. Reviewing the statistics available, we determine that 163 of these procedures have been performed. Charges ranged from \$ 1,150 to \$ 1,700. The average charge was \$ 1,013 . The 90th percentile figure is \$1,525. When we add the administrative allowance, the Reasonable and Customary allowance is \$1,605. The Group Medical Plan will, therefore, pay no more than this amount for a removal of a gallbladder in their geographic location.

EXAMPLE 2:

When a surgeon performs more than one procedure during the operative session, it is a common billing practice in the medical community to reduce the charge for any second and subsequent procedures. State Farm administers the reasonable and customary provision in accordance with this practice by allowing one-half of the actual R&C amount determined for each of the subsequent procedures. For example, at one operative session a patient has a vaginal delivery and a tubal ligation. The reasonable and customary allowance for the vaginal delivery is \$1,890 and \$960 for the tubal ligation. By considering one-half of the normal allowance for the tubal ligation, the total payment is \$2,370 (\$1,890+ ½ of \$960 or \$480).

EXAMPLE 3:

The American Medical Association establishes procedure codes for most surgical procedures in order to provide uniformity in coding practices. Some codes include procedures that are considered "inherent" or "incidental." Because these procedures add little to the difficulty or complexity of the primary surgery, it is appropriate to allow the reasonable and customary amount for the primary procedure only. No additional allowance for the "inherent" or "incidental" procedures would be appropriate. For example, a patient has a hysterectomy performed. When she received the bill, it was coded as follows:

<u>Code</u>	<u>Procedure</u>	<u>Charge</u>
58150	Total Hysterectomy	\$1,300
58720	Removal of ovaries/tubes	950
49000	Exploration of abdomen	671
44955	Appendectomy	250
58740	Removal of adhesions	<u>550</u>
	Total Charge	\$3,721

By definition, code 58150, Total Hysterectomy, includes removal of ovaries, tubes, exploration of the abdomen and removal of adhesions. The appendectomy is considered "incidental". Therefore no charge should have been made for it. If this claim had been appropriately coded, using 58150 and 44955, the charge would be \$1,300 for the total hysterectomy and no charge for the appendectomy.

REHABILITATION FACILITY:

A legally operated institution that provides coordinated multidisciplinary physical restorative services for the care and treatment of sick or injured resident inpatients which is:

- a. established and operated in accordance with the applicable laws of the state in which it is situated; and
- b. accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

This definition shall not include any institution including a rehabilitation facility or any part of a rehabilitation facility operated primarily as a clinic, nursing home, rest home, home for the aged, convalescent home, group home, half-way house, residential treatment facility or similar establishment.

RESPIRE CARE:

A short term inpatient stay which may be necessary for the Hospice care patient in order to give temporary relief to the person who regularly assists with home care.

ROOM AND BOARD CHARGES:

Charges made by a Hospital or Skilled Nursing Facility for the cost of the room, meals and services (such as general nursing services) that are routinely provided to all inpatients.

SKILL NURSING FACILITY:

An institution which is approved as such by Medicare.

TOTAL DISABILITY AND TOTALLY DISABLED:

The inability to engage, as a result of Illness, in the Employee's normal occupation with the employer, provided the Employee is not engaged in any occupation or business for wage or profit, and with respect to a Dependent, the inability to perform the usual and

customary duties or activities of a person in good health and of the same age and sex.

VISIT:

Each personal attendance of a Physician to the patient, regardless of the type of professional services rendered, whether it might be otherwise termed consultation, treatment, or given some other name.

BENEFITS:

Benefits are payable if an insured individual incurs Eligible Charges during a Benefit Period which exceed the Deductible amount. However, in no event shall any expense be payable under more than one of the benefits described below.

The charge for a service or a purchase shall be deemed to be incurred on the date the service is performed or the purchase is made.

Expenses incurred for the following will be considered Eligible Charges:

1. Room and Board Charges and routine nursing services for confinement in a Hospital or Rehabilitation Facility, excluding any private room charge in excess of the most common semiprivate room, unless the private room is considered Necessary Treatment. If the Hospital or Rehabilitation Facility does not have semiprivate rooms, its lowest private room charge will be considered eligible;
2. Semiprivate room and board and routine nursing services for confinement in a Skilled Nursing Facility (which is approved as such by Medicare) up to a maximum of 100 days confinement in each Benefit

Period; provided that the confinement is not for routine Custodial Care and that the patient is personally visited at least once every 30 days by his/her Physician. The benefit is reduced by the amount, if any, which is paid on payable for such confinement by Medicare. A Benefit Period means any one continuous period of confinement, whether due to one or more causes, and all successive periods of confinement due to the same or related cause or causes. A successive confinement will be considered as a new confinement, regardless of its cause, if it occurs after a period of 60 days or longer during which the individual has neither been confined in a Hospital nor a Skilled Nursing Facility;

3. Charges for confinement and/or care of alcoholism and/or drug abuse provided the facility furnishing such care is accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities;
4. Charges by a Hospital for medical services and supplies;
5. Anesthetics and their administration;
6. Fees of Physicians and surgeons for medical care, treatment and surgical operations rendered by and in the physical presence of the doctor, except that:
 - a. The maximum Eligible Charges for treatment of Mental or Nervous Disorders or psychoanalytic care for any reason rendered by a Physician or a social worker upon the referral of a Physician during a Visit by or to the patient will not exceed;
 - i. \$40 for each such Visit,
 - ii. one Visit on any one day, and

iii. 50 Visits during any calendar year.

The charges for treatment rendered by a social worker are Eligible Charges when the social worker is licensed or registered by the state in which these services are performed or is certified by the National Academy of Certified Social Workers.

This limitation is not applicable while the patient is confined as a resident in-patient in a Hospital;

- b. Charges for care in connection with the detection and correction by manual or mechanical means (including the application of treatment modalities such as, but not limited to diathermy, ultra-sound, heat and cold, etc.) of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column are limited to:
 - i. a payment of \$20 for each Visit,
 - ii. one Visit on any one day, and
 - iii. 50 Visits during any calendar year.

This limitation is not applicable if such services are rendered during general anesthesia, or during a cutting operation or while the patient is confined in a Hospital;

7. Services provided by a licensed physiotherapist at the direction of a Physician;
8. Fees for X-ray examinations (other than dental), microscopic and laboratory tests and other diagnostic services;

9. Fees for X-ray or radiation therapy;
10. Charges for necessary transportation of the individual by professional ambulance services, and when medically necessary, railroad or regularly scheduled airline to, and returning from, a Hospital or sanatorium equipped to furnish treatment for the illness (limited to transportation within the continental U.S. and Canada).
 - a. Transportation will be considered to be "necessary" transportation if it is due to emergency need or recommended by a Physician for the well-being of the patient, to the *nearest* Hospital equipped to render the necessary care. Necessary transportation does not include a mode of transportation selected solely for the convenience of the patient.
 - b. In case of transfer from one Hospital to another, transportation charges will be eligible only if the transfer is medically necessary and because the Hospital from which the patient is being transferred lacks the facilities necessary to treat the patient. Again, only transportation to the *nearest* Hospital capable of treating the patient will be eligible for payment.
 - c. Transportation charges to a Hospital for outpatient treatment will be eligible for payment only if such transportation is in connection with an emergency need related to an injury or illness;
11. Medical supplies if prescribed by a Physician as follows:
 - a. blood and other fluids (except insulin and associated syringes) to be injected into the circulatory system,

- b. artificial limbs and eyes for loss of natural limbs and eyes which occurred while insured,
- c. lens (contact or frames) for each eye immediately following and because of cataract surgery when required for protective rather than refractive purposes,
- d. casts, splints, trusses, braces, crutches and surgical dressings, and colostomy supplies,
- e. orthotic devices designed for a specific individual, stump socks, corrective or special shoes attached to a brace,
- f. rental of Durable Medical Equipment which satisfies all of the criteria as defined on page 4155. The Insurer also will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also Reasonable and Customary Charges and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient,
- g. rental of Durable Medical Equipment for kidney dialysis for the personal and exclusive use of the patient, so long as dialysis treatment continues to be medically required. The Insurer also will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also Reasonable and Customary Charges and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient;
- h. drugs and medicines which require a written prescription of a Physician, are dispensed by a

licensed pharmacist or Physician and are specifically supplied and billed by a Home Health Care program.

12. Charges by a Physician or qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to an illness, or to surgery on account of an illness;

13. a. Charges for the treatment of teeth, gums or alveolar process, or for dental appliances or supplies used in such treatment for Employees, Agency Managers, Trainee Agents, Retired Employees and Agency Managers who have continued their State Farm Dental Plan after retirement, and their Dependents, EXCEPT these charges are specifically limited to the following:

- 1) Hospital and surgicenter expenses.
- 2) Expenses incurred while insured as a result of and within 24 months after an accident suffered while insured hereunder for treatment of injury to natural teeth, including the replacement of such teeth or setting of a jaw fractured or dislocated in such accident. No benefits are payable for any accident occurring entirely within the mouth.

The time period for dental accidents for children under age 16 may be extended beyond 24 months provided the dentist presents a treatment plan within 24 months following the accident. The extension of dental accident benefits for these children will not be provided for any accident occurring entirely within the mouth. Benefits will be payable only if the child is insured on the date

service is finally rendered. The extension of benefits beyond 24 months will not apply to any individual whose accident occurs on or after the attainment of age 16.

- 3) Treatment of active periodontal disease, except:

- i. periodontal maintenance procedures (periodontal prophylaxis);
- ii. periodontal root scaling/planing;
- iii. surgical extraction of the teeth; or
- iv. osseous surgery.

13. b. Charges for the treatment of teeth, gums, or alveolar process, or for dental appliances or supplies used in such treatment for Retired Employees, Retired Agency Managers and their Dependents, except those who continued their State Farm Group Dental Plan after retirement, are specifically limited to the following:

- 1) Hospital and surgicenter expenses.
- 2) Expenses incurred, as a result of and within 24 months after an accident suffered while insured hereunder, for treatment of injury to natural teeth including the replacement of such teeth or setting of a jaw fracture or dislocation.

If such an accident results in damage to false teeth, in addition to injury to natural teeth, as a result of and within 24 months of said accident, expenses for treatment of damage to false teeth are also eligible charges.

The time period for dental accidents for children under age 16 may be extended beyond 24 months provided the dentist presents a treatment plan within 24 months following the accident. The extension of dental accident benefits for these children will not be provided for any accident occurring entirely within the mouth. Benefits will be payable only if the child is insured on the date service is finally rendered. The extension of benefits beyond 24 months will not apply to any individual whose accident occurs on or after the attainment of age 16.

- 3) Treatment of active periodontal disease, except:
 - i. periodontal maintenance procedures (periodontal prophylaxis); or
 - ii. surgical extraction of teeth.
- 4) Surgical removal of impacted teeth.
- 5) Treatment resulting from cancerous growths or osteomyelitis.
14. Charges for diagnosis, treatment and care of temporomandibular joint dysfunction except by dentures including full or partial plates or bridgework whether permanent or removable. The maximum payment is limited to \$2,000 in an individual's lifetime.

This limitation is not applicable to expenses incurred at a Hospital or Surgicenter.

15. Charges for the implantation or injection following surgical removal of all or a portion of the breast made necessary by infection or disease and subsequent

implantation or injections which result from infection or disease provided the initial implantation or injection was made necessary by infection or disease.

16. Charges for, or in connection with, reconstructive or Cosmetic Surgery when the surgery is the result of an accident suffered while insured hereunder. Charges for Cosmetic Surgery due to congenital defects for a child under age 10 will also be considered as Eligible Charges.
17. Charges
 - a. for confinement in a Christian Science sanatorium only with respect to those guests who are admitted for healing (not for rest or study) and who are under the care of an authorized practitioner. All charges by such sanatoria shall be deemed Hospital Room and Board Charges,
 - b. for services rendered by a Christian Science practitioner in the physical presence of a person and given in accordance with the healing practices of Christian Science, and
 - c. for professional nursing services rendered by a Christian Science nurse in accordance with the healing practices of Christian Science;
18. a. Services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for full-time, private duty nursing services rendered to an individual who is confined to a Hospital as a registered bed patient.
- b. Charges for full-time, private duty nursing services rendered to an individual who is not confined to a Hospital as a registered bed patient are limited to a maximum payment of \$5,000 per calendar year.

A Physician must prescribe these services and certify that the services:

- i. are being provided in lieu of Hospital confinement,
- ii. cannot be provided through intermittent home nursing Visits, and
- iii. cannot be provided by non-professional personnel such as an attendant, aide or the patient's family members,

19. Charges for Home Health Care rendered to an insured individual. Charges for such care are limited to a maximum of \$50 per Home Health Care Visit and a maximum payment of \$5,000 per calendar year.

The Home Health Care program must be prescribed by a Physician. The Physician must certify that the insured individual would otherwise have been confined in a Hospital or Skilled Nursing Facility.

For the purpose of this benefit, each Visit by a member of a Home Health Care team shall be considered as one Home Health Care Visit and four hours of home health aide service shall be considered as one Home Health Care Visit.

No benefits are payable for Home Health Care charges incurred for:

- a. services of a person who ordinarily resides in the insured individual's home or who is a member of such individual's family,
- b. Custodial Care,
- c. transportation services,
- d. any period during which the insured individual is not under the continuing care of a Physician,

- e. full-time, private duty nursing services,
- f. homemaker services, or
- g. meals delivered to the home.

Coverage under this Home Health Care benefit is also subject to the other exclusions, exceptions and limitations of this plan.

20. Charges for Hospice care rendered to an insured individual. However, charges for:

- a. care rendered to an individual not confined in a Hospital or Hospice facility as a registered bed patient are limited to a maximum lifetime payment of \$5,000.
- b. inpatient Respite Care are limited to a maximum of five days per confinement.
- c. bereavement counseling are limited to a maximum of five visits and \$40 per Visit per insured individual. Such counseling may occur before but no later than three months following the death of the individual who received Hospice care. Bereavement counseling will be considered an Eligible Charge if incurred by family members insured under this Master Policy.

No benefits are payable for Hospice charges incurred for:

- a. Custodial Care,
- b. financial and legal planning,
- c. funeral arrangements,
- d. homemaker services,
- e. services rendered by volunteers or individuals who do not regularly charge for their services,

- f. services rendered by a licensed pastoral counselor to a member of his/her congregation unless the pastoral counselor is an employee of the Hospice agency rendering such services, or
- g. the time period after the insured individual's death, except for bereavement counseling.

Coverage under this Hospice Care benefit is also subject to the other exclusions, exceptions and limitations of this plan;

- 21. Charges for a second surgical opinion and associated ancillary diagnostic services performed by a Board Certified Specialist other than the Physician who recommended the surgery or who is associated with the Physician who recommended the surgery. Charges for a third opinion will be considered an Eligible Charge if the second opinion indicates that surgery is not medically advisable. If the Physician certifies that a second (or third) surgical opinion was rendered, the Benefit Percentage for the second (and third) surgical opinion and associated ancillary diagnostic services will be 100%;
- 22. Charges for the educational or instructional care provided to an insured individual for the purpose of self-care, administration, and management of such insured individual's diabetic condition up to a \$100 lifetime maximum;
- 23. Charges for testing of a prospective organ donor who is an insured individual.

Charges for testing of prospective organ donors who are immediate family members of the recipient, provided the recipient is an insured individual. Immediate family members mean the recipient's

spouse, father, mother, brothers, sisters, sons and/or daughters.

In addition, a lifetime limitation of \$2,000 is provided for such charges incurred, regardless of the number of individuals tested, for other than immediate family members provided the recipient is an insured individual;

- 24. Medical services and supplies furnished by a Rehabilitation Facility;
- 25. Charges for treatment of Mental or Nervous Disorders provided in a Partial Hospitalization Program. Coverage is limited to 100 days of care per calendar year. The treatment must be provided (a) as a transition from, or an alternative to, inpatient hospitalization, (b) on a planned and regularly scheduled basis and (c) involve a minimum of three hours of care in any one day (which will be considered as a day of care). This benefit is not applicable when the patient is confined overnight as a resident inpatient;
- 26. Charges for investigational or experimental procedures and treatment only if all the following criteria are met.
 - a. The Physician must certify that accepted medical procedures have proven to be ineffective in the treatment of the diagnosed condition and that the condition, if not treated through investigational or experimental means, would be life threatening. Accepted medical procedures are those treatment modalities which meet the definition of Necessary Treatment.
 - b. The investigational or experimental treatment must be performed at a facility which has been

designated by the appropriate Federal regulatory body to perform the procedure.

- c. The investigational or experimental treatment must be under an active investigative protocol. Procedures which have been determined to be unproven following an investigative protocol will not be eligible for payment.
- d. The expenses must not have been reimbursed, or be eligible for reimbursement, under any state or Federal grant, study, fund, endowment or other public or private funding mechanism.

If the above criteria are met the investigational or experimental treatment will be eligible subject to all other policy provisions and a maximum lifetime benefit of \$250,000 per individual;

- 27. Charges for well-baby care services rendered by a Physician during the first 24 months of an Individual's life. Well-baby care includes, but is not limited to, regularly scheduled check-ups, immunizations, laboratory tests and other associated screening or diagnostic services that occur subsequent to the Individual's initial Hospital confinement at birth. The Benefit Percentage for well-baby care services will be 100% and will not be subject to the Deductible. This benefit is limited to \$100 per calendar year per Individual.

- 28. Charges for preventive diagnostic tests and procedures listed below:

- a. Screening Mammography

Individual age 35-39: one baseline mammogram during these years

Individual age 40-49: one mammogram every other year

Individual age 50 and over: one mammogram every year

- b. Serum Cholesterol Test

One test per individual per year

- c. Resting Electrocardiogram (EKG)

Individual age 35-39: one baseline EKG during these years

Individual age 40-49: one EKG every other year

Individual age 50 and over: one EKG every year

- d. Tetanus Immunization

- e. Influenza Immunization

- f. Papanicolaou Test (Pap Smear cervical or vaginal only)

One test per individual per year

- g. Fecal Occult Blood Test

One test per individual per year

Reimbursement of any Physician's office charge performed in association with the preventive diagnostic test(s) or procedure(s) listed above will be limited to a maximum of \$30.

The above services will be covered at 100% and will not be subject to the Deductible.

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFIT:

Charges for outpatient drugs and medicines (including insulin and associated syringes (which require a written

prescription of a Physician and which must be dispensed by a licensed pharmacist or Physician will be considered for reimbursement. However, reimbursement for these charges will be administered under an agreement with Medco Containment Services, Inc. as follows:

1. Prescription Drug Card Option

Upon submission of the written prescription and Paid Prescriptions ID card to a Participating Pharmacy, the insured Individual will be responsible for a \$7.00 copayment per name brand prescription or refill (maximum 30 day supply) or \$400 copayment per generic prescription or refill (maximum 30 day supply). No other deductible or copayment will apply.

Participating Pharmacy means a pharmacy recognized as a Participating Pharmacy under the agreement with Medco Containment Services, Inc.

Expenses incurred at non-Participating Pharmacies or at Participating Pharmacies when the Prescription Drug Card is not used will be reimbursed under the basic pricing formula used by Paid Prescriptions, Inc. to reimburse Participating Pharmacies. The basic pricing formula is the average wholesale price plus a dispensing fee plus an administrative fee. The insured Individual will have to pay any charges above this amount plus the \$7.00 or \$4.00 copayment amount.

2. Mail-order Option

Upon submission of the written prescription to National RX Services, Inc. the insured Individual will be responsible for a \$3.00 copayment per prescription or refill (maximum 90 day supply). No other deductible or copayment will apply.

3. Prescription drugs covered under this program are:

- all Federal Legend drugs
- all state restricted drugs
- compound medications which contain at least one Federal Legend drug
- insulin with or without a prescription (NOTE: Mail Service requires a prescription)
- insulin syringes (NOTE: Mail Service requires a prescription)
- syringes unless specifically excluded below

4. Prescription drugs not covered under this program are:

- birth control pills, diaphragms, jellies, ointments, foams, condoms and other birth control devices regardless of intended use.
- smoking deterrents
- all over-the-counter (non-prescription) drugs except insulin
- therapeutic devices/appliances
- investigational/experimental drugs
- drugs whose primary use is to stimulate hair growth
- anorexients/amphetamines
- medications for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medications furnished by any other drug or medical service for which no charge is made to the member

- diabetic supplies such as lancets, autolet, sugar test tablets, etc.*
- allergy serum*
- allergy syringes*
- drugs provided by a Home Health Care Agency*

*These items are eligible for consideration under the Group Insurance Option and should be submitted with the standard claim form to State Farm.

For the purpose of this provision, the Annual Deductible, Coinsurance, Benefit Period, Maximum Benefit, Pre-Existing Conditions, and Coordination of Benefits provisions are not applicable. In no event will benefits be payable under both this provision and any other plan Benefits. All other Group Insurance option provisions apply to this benefit.

UTILIZATION REVIEW:

Hospital admissions and length of Hospital stays are subject to review by a professional review organization designated by the Insurer.

1. Pre-Admission Notification Requirements

It is the responsibility of the insured Individual or his/her family to notify such organization:

- a) prior to admission to a Hospital for non-emergencies; or
- b) within 2 business days following an emergency admission to a hospital.

2. Effect on Benefits

If the professional review organization is not notified in accordance with the requirements stated above, any Hospital charges that are otherwise Eligible

Charges will be reduced by \$300. The remaining eligible Charges will be subject to the Deductible and co-payment amount.

3. Limitations

- a) Notification to the professional review organization is not required when Medicare is primary.
- b) Notification to the professional review organization pursuant to the requirements stated above does not guarantee payment of any charges in connection with the Hospital admission. Such charges are subject to all other policy provisions, exclusions, exceptions and limitations.

INELIGIBLE CHARGES:

All charges Not Specifically Listed in the Benefits section, including:

1. Charges as a result of any Illness which arise out of or in the course of any employment for which the individual is entitled to or eligible to receive benefits under any Workers' Compensation or Occupational Disease law, or receives any settlement from a Workers' Compensation carrier;
2. Charges due to war or any act of war, whether declared or undeclared;
3. Charges incurred when the individual is not under the direct care of a Physician;
4. Charges which the individual is not legally obligated to pay;
5. Charges which are in excess of the Reasonable and Customary Charge for the services performed and the materials furnished;

6. Charges for any services, supply or Hospital confinement which are not considered Necessary Treatment of an Illness;
7. Charges for losses incurred while the individual is in the military, naval, air force or other armed services of any country;
8. Charges for which benefits are not specifically provided under this Policy;
9. Charges for the treatment of teeth, gums or alveolar process, or for dental appliances or supplies used in such treatment, EXCEPT those services listed under the Benefits section;
10. Charges for hearing aids or examinations to determine the need for, or the proper adjustment of, hearing aids;
11. Charges for eyeglasses and contact lenses or Physician's services in connection with eye refractions or any other examinations to determine the need for, or proper adjustment of, eyeglasses or contact lenses;
12. Charges for radial keratotomies, acupuncture (includes, but is not limited to, acupuncture by needle, electrical stimulation, ultrasound, acupressure, laser and articular therapy) or thermography;
13. Charges for, or in connection with, care, treatment or operations which are performed for cosmetic purposes, EXCEPT for the services described in the Benefits section;
14. Charges for hospitalization, services, treatments or supplies furnished by the United States or a foreign

- governmental agency unless otherwise prohibited by law;
15. Charges for medical treatment by a Physician for any treatment which is not rendered by or in the physical presence of the Physician;
 16. Charges for services provided by a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed physiotherapist who ordinarily resides in the same household with the insured individual or who is related by blood, marriage, or legal adoption to the insured individual or his/her spouse.
 17. Charges incurred in connection with a Preexisting Illness(es) will be limited as described in the Preexisting Illness(es) section;
 18. Charges for reversal of sterilization procedures, either male or female;
 19. Charges for Custodial Care or care which is primarily for custodial or domiciliary purposes;
 20. Charges for any and all expenses incurred beyond the termination date of coverage unless specifically allowed for by an Extension of Coverage or Continuation of Coverage situation;
 21. Charges for educational, instructional, or vocational training except this exclusion does not apply to the expenses described in Benefit #22;
 22. Charges for treatment, therapy or related services given to maintain functioning at the level to which it has been restored or when no further practical improvement can be expected;
 23. Charges for expense resulting from modifications made to a home, automobile/van, or other real or personal property. This would include but is not

limited to items such as ramps, elevators, spa, air cleaning or filtration systems and car hand controls;

24. Charges for any drug or medicine which is not approved by the Food and Drug Administration (FDA);
25. Charges for expenses resulting from exercise, diet or weight loss programs or treatment, including nutritional evaluations and food supplements; or facilities providing such treatment, regardless of the reason for the programs or treatment;
26. Charges for cardiac rehabilitation programs or treatment unless the Eligible Charges are incurred within eighteen weeks of hospitalization due to a heart attack, open heart surgery or balloon angioplasty procedures;
27. Charges for routine, periodic or annual examinations or diagnostic tests which are performed primarily for preventative or health screening purposes, EXCEPT those services listed under Benefit #28;
28. Charges for in vitro fertilization or other means of artificial insemination.
29. Charges for expenses resulting from any smoking cessation program or any treatment for tobacco or nicotine dependence.
30. Charges for diagnosis, care or treatment of Developmental Disorders or learning disturbances regardless of age.

PRE-EXISTING CONDITIONS:

For all Employees and Dependents who enrolled for coverage when first eligible, there is a \$2,000 maximum

payment for care and treatment of a Pre-existing Illness(es) until:

- a. there is a period of 3 months ending after the insured individual's effective date, without any care or treatment for the condition(s), or
- b. a period of 12 months after the individual's effective date of coverage.

For all other Employees and Dependents for whom evidence of insurability was required as a condition of being insured, there is a \$500 maximum payment for care and treatment of a Pre-existing Illness(es) until:

- a. there is a period of 3 months ending after the insured individual's effective date, without any care or treatment for the condition(s), or
- b. a period of 12 months after the individual's effective date of coverage.

The maximum payment amounts referenced above for care and treatment of a Pre-existing Illness(es) will be reduced by the amount of benefits paid, if any, under Master Policy

Pre-existing Illness(es) is defined in the Definitions section.

EXTENSION OF COMPREHENSIVE MEDICAL COVERAGE:

If on the termination of the Master Policy the Employee is Totally Disabled by an Illness, coverage for the individual will be extended during the subsequent period of continuous Total Disability, but for not longer than 12 months after the date of termination, solely for Illnesses incurred prior to the termination of the Master Policy.

COORDINATION OF BENEFITS:

If a person is covered for medical care or treatment benefits under any other plan of coverage:

- a. for individuals in a group, whether on an insured or uninsured basis;
- b. provided under Medicare or any other governmental program; or
- c. provided in group, group-type and individual "no-fault" and traditional "fault" type contracts,

the benefits of this insurance option may be reduced so that during the calendar year up to, but not more than, 100% of the person's medical or dental expenses (at least a portion of which is covered under one or more of such plans) will be paid by all such plans.

Where payment has been made under any other plan when it should have been made under this insurance option, the Insurer will have the right to adjust the payment directly with the other insurance company, organization, or person making such other payment.

If a person is covered for medical care or treatment under any other plan, as defined above, the order of benefit determination (primary vs. secondary) will be determined by using the first of the following rules which apply:

1. **DEPENDENT/NON-DEPENDENT** The plan that covers the person as an employee, member or subscriber will be primary.
2. **DEPENDENT CHILD/PARENTS NOT DIVORCED OR SEPARATED —**

- i. The plan of the parent whose birthday (month and day) falls earliest in the year will be primary.
- ii. If both parents have the same date of birth, the Plan that covered a parent the longest will be primary.
- iii. If the other Plan does not have the rules described in i. and ii. above, but instead has a rule based on the gender of the parent, the rule of the gender Plan will determine primacy.

3. **DEPENDENT CHILD/PARENTS DIVORCED OR SEPARATED —**

- i. First, the Plan of the parent with custody of the child.
- ii. Then, the Plan of the spouse of the parent with custody of the child.
- iii. Finally, the Plan of the parent not having custody of the child.

EXCEPT if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the individual obligated to pay or provide health care benefits has actual knowledge of that obligation, that parent's Plan will be primary.

4. **ACTIVE/INACTIVE EMPLOYEE —** The Plan that covers a person as an active employee (not laid off or retired) will be primary.
5. **LONGER/SHORTER LENGTH OF COVERAGE —** If none of the above rules determine primacy, the Plan that has covered an

employee, member or subscriber the longest will be primary.

EXAMPLES SHOWING HOW THE INSURANCE OPTION WORKS:

EXAMPLE NO. 1

Example No. 1 illustrates how the insurance option works when no other coverage is involved.

	Option A	Option B	Option C
Hospital Room and Board	\$ 600.00	\$ 600.00	\$ 600.00
Hospital Other Charges.....	425.00	425.00	425.00
Anesthesia.....	100.00	100.00	100.00
Surgery.....	400.00	400.00	400.00
Private Nurse	250.00	250.00	250.00
Total Expenses.....	\$1,775.00	\$1,775.00	\$1,775.00
Less Deductible	-100.00	250.00	500.00
Total Eligible Expenses	\$1,675.00	\$1,525.00	\$1,275.00
*Insurance pays 80%	\$1,340.00	\$1,220.00	
75%			\$ 956.25
Insured pays 20%.....	\$ 335.00	\$ 305.00	
25%			\$ 318.75

EXAMPLE NO. 2

Example No. 2 assumes the same expenses as Example No. 1 but the individual is also covered by other insurance which, according to the established Coordination of Benefits rules, is required to pay its benefits first. Although this example shows that the insured pays nothing, it is possible under certain situations, for the Insured to be obligated for some payment.

	Option A	Option B	Option C
Total Expenses.....	\$ 600.00	\$ 600.00	\$ 600.00
Assume Medicare (or other Insurance) plan pays	1,000.00	1,000.00	1,000.00
This Insurance pays	775.00	775.00	775.00
the balance up to above.			
Insured pays	Nothing	Nothing	Nothing

MEDICAL RECORDS TO SUBSTANTIATE CLAIMS:

It is necessary to keep separate records of your expenses with respect to yourself and each of your Dependents. Original copies of all itemized statements are necessary to support a claim when State Farm is the primary carrier.

Itemized statements should always include:

1. Name of person or organization making the charge, i.e. doctor, Hospital, nurse, drugstore, etc.
2. Date of treatment or purchase.
3. Type of treatment performed or materials furnished.
4. Amount charged.
5. Name of patient.
6. Name and prescription number of drugs or medicine

A doctor's statement must be provided on request.

Cash register receipts, cancelled checks, money order stubs, etc., are not acceptable as bills for medical expenses.

TERMINATION OF INSURANCE:

The Master Policy may be terminated by the Insurer on any premium due date upon written notice to the

Policyholder at least 31 days in advance if the enrollment is below 75% of the total number of Employees eligible for insurance.

The Insurer may also terminate the Master Policy at the end of the grace period (as specified in the Master Policy) if premiums due have not been paid.

The Master Policy may be terminated by the Policyholder at any time.

Your insurance may be terminated by the Policyholder if you submit, or cause to have submitted in your behalf, a claim containing a material misrepresentation.

Your medical insurance will automatically terminate on the earliest of the following dates: the date the Master Policy terminates, the last day of the calendar month coincident with or next following the date of termination of employment, the date of the expiration of the last period for which you have made a contribution or allocated Flexible Compensation dollars, the last day of the month in which you otherwise cease to be eligible for insurance, or the last day of the month in which you enter military, naval, air force or other armed services of any country. The insurance for a Dependent automatically terminates on the earliest of the following dates: the date coverage for Dependents is terminated under the Master Policy, the date your insurance terminates, the last day for which your Dependent's premium has been paid, with regard to a spouse the last day of the month during which you become divorced or legally separated, the last day of the month in which the Dependent enters the military, naval, air force or other armed services of any country, and with regard to a child the last day of the month in which the child marries or ceases to receive over 50% of his/her annual support from his/her parents, or the last day of the calendar year during which the child attains age 23

or becomes eligible for coverage as a State Farm Employee or agent.

The maximum age limit for children does not apply to a child who is on the date he/she attains the maximum age, and continues to be, both (a) mentally or physically incapable of earning his/her own living and (b) chiefly dependent on the Employee for over 50% of his/her annual support and maintenance as long as such dependency and incapacity continues if due proof of the continuance of such dependency and incapacity is furnished to the Insurer as it may reasonably require. The Insurer will request and require proof of the incapacity and dependency of such a Dependent as of the date of claim but may not request or require such proof sooner than two months prior to the date on which the person attains the maximum age. In, the absence of proof submitted within 31 days of such inquiry, the Insurer may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any disabled and dependent person shall continue through the term of such policy or any extension or renewal thereof.

CONVERSION:

If your coverage terminates while the Master Policy continues in force, you may be eligible to convert your coverage and the coverage of your Dependents, who were insured with you to a conversion policy. In addition, conversion is available to children who marry or reach the maximum age limit and to your former spouse in the event of dissolution of your marriage or upon your death. It is also available at the end of any continuation of coverage time period.

A conversion policy will not be issued to an insured individual who is eligible for Medicare or who has similar benefits provided by another plan.

Application for conversion must be made within 31 days after coverage under the group terminates. If you are eligible for conversion and apply within the time allowed, a conversion policy will be issued without medical evidence of insurability.

The benefits of the individual policy will not be the same and may be considerably less than the benefits of the Master Policy. For information secure a Conversion Application from the Regional Office Personnel Department.

PREFERRED PROVIDER ORGANIZATION:

Preferred Provider means a Hospital or other health care facility recognized as such by State Farm and AFFORDABLE Health Care Concepts. Names and addresses of Preferred Providers can be obtained from the Provider Directory.

When Eligible Charges are incurred through a Preferred Provider, the Benefit Percentages will be increased 10% (but not to exceed 100%) for such Eligible Charges which exceed the Deductible except that the Benefit Percentages for Eligible Charges incurred for the care or treatment of alcohol abuse, drug abuse, or Mental or Nervous Disorders will be increased 10% for the first \$8,000 of Eligible Charges in any calendar year and thereafter will be payable at 80% for Option A and B and 75% for Option C. When a Benefit specifies a maximum allowance (for example dollar amount) and the maximum has been reached, the insured Individual is responsible for charges above the Benefit maximum amount.

This Benefit does not apply to the Benefits described in item #6 in the Benefits Section (see page 4215).

This provision shall become effective on the date designated by the Policyholder and the benefits provided by the provision shall be applicable to Eligible Charges incurred while the provision is in effect. This provision shall terminate on the date designated by the Policyholder.

GENERAL INFORMATION:

You have 20 days from the date of commencement of the loss to give the Insurer written notice of injury or sickness upon which you base your claim. Following notice of injury or sickness, you will receive a claim form so that you may file proof of loss.

You have 90 days after the date of loss to furnish proof of loss to the Insurer.

If you do not furnish notice or proof within the time allowed, your claim will still be considered if you show that it was not reasonably possible to furnish the notice or proof within the time allowed and that the notice or proof was furnished as soon as was reasonably possible. However, in no event will a claim be considered if proof of loss is submitted later than 15 months after the date of loss.

Any benefits provided in the Master Policy will be paid immediately after receipt of proof of loss. All benefits are payable to you unless subject to a valid assignment. If you die before the Insurer makes payment of the benefits, payment will be made to your estate; or, at the Insurer's option, to your widow or widower, if living; otherwise to your living children, if any; otherwise to your parents, if living.

The Insurer reserves the right to allocate the Deductible amount to any Eligible Charges and to apportion the benefits to the Employee and any assignees.

No action at law or in equity shall be brought to recover on the Master Policy prior to the expiration of 60 days after proof of loss has been filed, nor shall action be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the Master Policy.

The Insurer reserves the right and opportunity to examine the person whose injury or sickness is the basis of claim as often as it may reasonably require during pendency of the claim.

This insurance is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

If you should be unable to work because of disability, leave of absence, or temporary layoff, or should you be retired, inquire of the Policy-holder as to your rights, if any, under the Master Policy.

CLAIM AND REVIEW PROCEDURE:

When you need to file a claim,

HOW TO FILE A CLAIM:

1. Contact the Group Insurance Benefits Specialist in your Personnel Department for the appropriate claim form. It is important that the form be filled out carefully and completely since missing or incomplete answers may delay payment.
2. You must complete and sign the claim form (one form per patient).

3. A separate Physician/supplier statement is sometimes required. If so, you will be given the form to be completed by the doctor.
4. Return the completed form(s) and available medical bills documenting the charges incurred to the Group Medical Insurance Division, State Farm Mutual Automobile Insurance Company, Bloomington, Illinois.

PROCESSING CLAIMS:

The Group Medical Insurance Division will,

1. Review the claim form for completeness, and
2. Determine if your claim meets the provisions of the Master Policy. This review process usually takes about 30 days from the date the claim was filed. When more time is necessary, the Group Medical Insurance Division will have up to 90 days (after receipt of the claim) to make a determination.

Special circumstances may require a further extension of time for processing the claim. In these cases, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. The extension notice will indicate,

- a. The special circumstances requiring an extension of time, and
- b. The date which the Group Medical Insurance Division expects to render the final decision.

This extension will not exceed 90 days from the end of such initial period.

PAYMENT OF CLAIM:

If payment is authorized, the Group Medical Insurance Division will release whatever benefits are payable.

DENIAL OF CLAIM:

If your claim is denied, the Group Medical Insurance Division gives you written notice of the denial. The written notice provides the following:

1. The specific reason or reasons for the denial.
2. Specific reference to pertinent plan provisions on which the denial is based.
3. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
4. Appropriate information as to the steps to be taken to submit the claim for review.

REVIEW PROCEDURE:

If your claim is denied, you or your authorized representative may request a review of your claim. You will need to put your request in writing and submit it to the Group Insurance Benefits Specialist. The request should include documents, reports, or other evidence to support your position. To help you prepare your request, you may examine any pertinent plan documents. Your request for review must be made within 60 days of the receipt of notice of the denial of your claim. If such a request is not made within 60 days, you will be deemed to have waived your right to a review by the Plan Administrator.

The Group Insurance Benefits Specialist will forward your request for review along with the entire file to the

Corporate Benefits and Services Division of General Personnel, Corporate Headquarters. They will make a decision not later than 60 days after the request for review is submitted, unless special circumstances require an extension of time for processing. In this case, a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review. The decision on review will be in writing and will include specific reasons for the decision. It will be written in readily understandable language and will refer to the pertinent plan provisions on which the decision is based. If the decision on review is not furnished within the time limits described in the preceding paragraph, the claim shall be deemed to be denied on review.

SECTION III**HEALTH MAINTENANCE ORGANIZATION**

State Farm employees may choose a health maintenance organization (HMO) as an alternative health care choice. In general, the primary differences between an HMO and Group Medical Insurance are that claim forms need not be completed when seeking medical care, health care is provided by a physician associated with the HMO, deductibles are sometimes not associated with health care provided, and treatment by providers not associated with the HMO must be by referral from an associated physician. Treatment outside of the service area is restricted to emergency care. (There may be other differences that are not noted here.)

NOTE: YOU ARE ELIGIBLE TO PARTICIPATE IN AN HMO ONLY IF YOU LIVE IN THE SERVICE AREA FOR THE HMO.

Upon request, information will be provided to any employee interested in the HMOs listed. Information in the form of

written materials concerning (a) the nature of services provided to members; (b) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participating in the HMO) and circumstances under which services may be denied; (c) the procedures to be followed in obtaining such services; and (d) the procedures available for the review of claims for services which are denied in whole or in part.

Requests for any of the information listed in the above paragraph may be directed to the Plan Administrator and the Plan Administrator will forward all requests to the appropriate HMO carrier. A brief summary of each HMO's benefits, grievance procedures and procedures for submitting eligible expenses appears in the appendix.

Although State Farm Mutual Automobile Insurance Company is the Plan Administrator and Plan Sponsor for the Group Medical Plan (including HMO alternatives), any and all benefit determinations will be made by each individual HMO according to its operating procedures.

TERMINATION OF HMO BENEFITS:

Coverage under any HMO offered may terminate for any of the following reasons:

1. Nonpayment of monthly premium or co-payments.
2. Expiration of the month in which a subscriber becomes ineligible.
3. Inability to establish and maintain a satisfactory physician/patient relationship.
4. Fraud or deception knowingly committed by the enrolled subscriber.
5. Misuse of the HMO identification card.

6. Disruptive, threatening, unruly, abusive and/or uncooperative behavior.

SOURCES OF CONTRIBUTION:

The premiums for the HMO coverage are shared by the employee and State Farm. Your share of the premium may be paid with pre-tax (flexible compensation) dollars according to the terms of the State Farm Insurance Companies Flexible Compensation Plan for U.S. employees, or with after-tax dollars deducted from your paycheck.

State Farm pays at least 50% of the HMO premium amount. In some instances, State Farm could pay more than 50% of the premium amount. This may be necessary to allow flexibility in HMO pricing and equity for all employees participating in the Group Medical Insurance option.

For more detailed information on HMOs available in your area, see the Appendix.

HEALTH MAINTENANCE ORGANIZATION APPENDIX

THIS APPENDIX TO THE HMO SECTION IS NOT MEANT TO BE ALL INCLUSIVE OF BENEFITS AND RESTRICTIONS PROVIDED BY THE HMO. FOR A SCHEDULE OF ALL BENEFITS AND RESTRICTIONS, PLEASE CONTACT THE PLAN ADMINISTRATOR AND REQUEST ADDITIONAL INFORMATION. THE HMO WILL BE ASKED TO SEND MORE DETAILED INFORMATION TO YOU.

On the following pages we have tried to describe the benefits available under the various HMO options.

This information has been obtained directly from the HMO's contract or HMO's Representative. If the following information contains any statements that disagree with the HMO contract, then the HMO contract shall govern.

10
No. 98-1949

Supreme Court, U.S.

FILED

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IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
and HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH
Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

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November 19, 1999

QUESTION PRESENTED

Whether a health maintenance organization ("HMO") and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1104(a)(1), by implementing a managed-care program in which the HMO and its physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

PARTIES TO THE PROCEEDING

All parties to the proceeding are listed in the caption of the case. There are no additional parent companies or nonwholly owned subsidiaries of the parties. See Sup. Ct. R. 29.6.

TABLE OF CONTENTS

QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
STATUTE INVOLVED	2
STATEMENT OF THE CASE	2
SUMMARY OF ARGUMENT	15
ARGUMENT	20
I. AN HMO AND ITS PHYSICIANS DO NOT ACT AS FIDUCIARIES BY IMPLEMENTING COST-CONTAINMENT INCENTIVES	22
A. State Farm's Plan Design Decisions Rendered Petitioners' Implementation Of The Cost-Containment Mechanism At Issue Not Subject To Fiduciary Duties	24
B. Even Assuming That Implementation Of Financial Incentives For Cost-Containment Is Not A Plan Design Decision, Petitioners' Implementation Of Such Incentives Is Not Fiduciary In Nature	31

II.	AN ALLEGATION THAT AN HMO FINANCIALLY REWARDS ITS OWNER PHYSICIANS FOR SUCCESSFUL COST-CONTAINMENT DOES NOT STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY	43
III.	HERDRICH'S FAILURE TO ALLEGE DAMAGE TO THE PLAN DEMONSTRATES THAT SHE FAILED TO STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY	48
	CONCLUSION	50

TABLE OF AUTHORITIES

CASES	Page
<i>Adams v. Avondale Indus., Inc.</i> , 905 F.2d 943 (6th Cir. 1990)	21
<i>Alessi v. Raybestos-Manhattan, Inc.</i> , 451 U.S. 504 (1981)	21
<i>American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.</i> , 973 F. Supp. 60 (D. Mass. 1997)	41
<i>American Mfrs. Mut. Insurance Co. v. Sullivan</i> , 119 S. Ct. 977 (1999)	3
<i>California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.</i> , 519 U.S. 316 (1997)	36
<i>Corcoran v. United HealthCare, Inc.</i> , 965 F.2d 1321 (5th Cir. 1992)	38
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<i>Dukes v. U. S. Healthcare, Inc.</i> , 57 F.3d 350 (3d Cir.1995)	38
<i>FTC v. Indiana Federation of Dentists</i> , 476 U.S. 447 (1986)	3
<i>Fort Halifax Packing Co. v. Coyne</i> , 482 U.S. 1 (1987)	24
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<i>Herdrich v. Pegram</i> , 170 F.3d 683 (7th Cir. 1999)	1
<i>Hughes Aircraft Co. v. Jacobson</i> , 119 S. Ct. 755 (1999)	<i>passim</i>
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	<i>passim</i>
<i>Lupo v. Human Affairs Int'l, Inc.</i> , 28 F.3d 269 (2d Cir. 1994)	38
<i>Mackey v. Lanier Collection Agency & Serv., Inc.</i> , 486 U.S. 825 (1988)	36
<i>Maltz v. Aetna Health Plans</i> , 152 F.3d 919 (2d Cir. 1998) (table)	42,46
<i>McEvoy v. Group Health Coop.</i> , 570 N.W.2d 397 (Wis. 1997)	42

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<i>Morton v. Mancari</i> , 417 U.S. 535 (1974)	40
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<i>Ouelette v. Christ Hosp.</i> , 942 F. Supp. 1160 (S.D. Ohio 1996)	42
<i>Pacificare, Inc. v. Burrage</i> , 59 F.3d 151 (10th Cir. 1995)	38,41
<i>Pappas v. Asbel</i> , 724 A.2d 889 (Pa. 1998), <i>petition for cert. filed</i> , 67 USLW 3717 (U.S. May 13, 1999) (No. 98-1836)	42
<i>Petrovich v. Share Health Plan, Inc.</i> , No. 85-726 (Ill. filed Sept. 30, 1999)	42
<i>Physicians Health Plan, Inc. v. Citizens Insurance Co. of Am.</i> , 673 F. Supp. 903 (W.D. Mich. 1987)	41
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<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	21,34,44
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--	----

<i>Wilson v. Blue Cross</i> , 271 Cal. Rptr. 876 (Cal. Ct. App. 1990)	42
--	----

FEDERAL STATUTES, REGULATIONS AND RULE

29 U.S.C. § 1002	<i>passim</i>
§§ 1021-1031	20
§§ 1101-1114	20
§ 1102(a)(1)	20
§ 1104	2,21,30
§ 1106(a)	18,35
§ 1108(c)(3)	44
§ 1109	49
§ 1112	18,35
§ 1144	<i>passim</i>
42 U.S.C. § 300e	5,16,19,29
§ 300e-10(a)	19
§ 1102	48
§ 1103	48
§ 1395mm	5,19,40
§ 1395w-25	6,40
§ 1396b(m)	5,19,40
42 C.F.R. § 417.479	40

STATE STATUTES

Me. Rev. Stat. Ann. tit. 24-A, §§ 2671-2676	40
N.Y. Pub. Health Law §§ 4400-4413	40
N.D. Cent. Code §§ 26.1-18.1-01 to -25	40
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OPINIONS BELOW

The opinion of the court of appeals and the dissent thereto (App. 1a-47a) were entered on August 18, 1998, and are reported at 154 F.3d 362 (7th Cir. 1998). The order of the court of appeals denying the petition for rehearing and the suggestion for rehearing *en banc* was entered on March 8, 1999; that order and the dissent from the denial of rehearing *en banc* (App. 48a-58a) are reported at 170 F.3d 683 (7th Cir. 1999). The opinion of the United States District Court for the Central District of Illinois, adopting the magistrate judge's recommendation that petitioners' motion to dismiss Count III of respondent's amended complaint (the count at issue here) should be granted (App. 59a-60a), is not reported. The recommendation of the magistrate judge (App. 61a-64a) is not reported. A previous opinion of the district court, granting petitioners' motion for summary judgment on two state-law counts in respondent's complaint, but also granting respondent leave to amend her complaint to state a claim under the Employee Retirement Income Security Act (App. 65a-80a), is not reported. The February 10, 1997 judgment of the district court reflecting the jury verdict in this case (App. 81a-82a) is not reported.

JURISDICTION

The court of appeals entered its judgment on August 18, 1998. Petitioners timely filed a petition for rehearing and suggestion for rehearing *en banc* on September 1, 1998. On March 8, 1999, the court of appeals issued its decision and order denying petitioners' petition for rehearing and suggestion for rehearing *en banc*. App. 48a-58a. Petitioners timely filed their petition for certiorari on June 4, 1999, and this Court granted the petition on September 28, 1999. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act of 1974 ("ERISA"), specifically section 3(1), 29 U.S.C. § 1002(1), which is set forth *infra* at 22, section 3(21)(A), 29 U.S.C. § 1002(21)(A), which is set forth *infra*, at 20, and section 404(a)(1), 29 U.S.C. § 1104(a)(1), which provides:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and --

(A) for the exclusive purpose of:

- (i) providing benefits to participants and their beneficiaries; and
- (ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

STATEMENT OF THE CASE

1. In the decision below, the court of appeals held that a health maintenance organization ("HMO") and its owner physicians act as fiduciaries within the meaning of ERISA when they implement a system of managed care in which they earn additional income if the HMO succeeds in providing cost-effective care. The court also held that the allegation that an

HMO and its physicians have adopted such a mechanism states a claim for breach of fiduciary duty under ERISA.

This case is the product of the relatively recent, substantial changes in the method by which health care is delivered and paid for in this country. Traditionally, health care in the United States was provided on a fee-for-service basis, and physicians and other providers of medical services were separate from the entities responsible for paying for that health care (usually, insurers). A physician provided the medical treatment; bills were submitted to an insurer which paid those bills pursuant to the terms of the insurance contract. In the late 1960s and early 1970s, rapid and dramatic increases in health-care costs led to the development of alternative forms of health-care delivery and financing, including HMOs, preferred-provider organizations, and other forms of "managed care."

Generally, in a managed-care arrangement, enrollees receive comprehensive health-care coverage in exchange for a fixed premium. A managed-care organization arranges for the enrollees' care by employing or entering into independent contracts with providers. Because managed-care organizations generally assume some or all of the financial risk of providing health care, they have a strong incentive to control costs and to provide preventive care. Costs are "managed" through a variety of administrative mechanisms, such as utilization review, medical necessity determinations, and pre-certification of care. See, e.g., *American Mfrs. Mut. Insurance Co. v. Sullivan*, 119 S. Ct. 977, 982-83 (1999); *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 449 (1986). These devices are often linked with financial incentives for participating physicians to reduce the utilization of unnecessary or overly costly services.¹

¹ U.S. General Accounting Office, GAO/HRD-94-3, *Managed Health Care -- Effect on Employers' Costs Difficult to Measure* 4-5 (1993) ("GAO Report"); (continued...)

Cost-containment measures are now routinely used by health insurers and managed-care organizations.² In addition, a substantial majority of HMOs use financial rewards and penalties for health-care professionals to provide incentives for cost-effective treatment.³

Congress has recognized and sought to support the development of managed-care arrangements. In the early 1970s, faced with an explosive increase in medical costs, Congress decided that HMOs represented an important alternative to traditional fee-for-service medicine and that the development of this alternative was threatened by the hostility of state regulators. In response to these concerns, Congress enacted the HMO Act of 1972. The HMO Act expressly authorized and approved the HMO arrangement for health-care delivery. It *required* HMOs to assume financial risk for the care of participants and specifically authorized HMOs to enter into contracts that financially reward their physicians for minimizing expensive treatment:

Each [HMO] shall . . . assume full financial risk on a prospective basis for the provision of basic health services, except that a[n] [HMO] may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial

¹ (...continued)

D. C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?* 83 Geo. L.J. 1821, 1821 (1995) (citing Stanley S. Wallack, *Managed Care: Practice, Pitfalls and Potential*, Health Care Financing Rev. 1991, Ann. Supp. 27)).

² See also McGraw, *supra*, at 1823 & n.12.

³ See GAO Report, *supra*, at 30; McGraw, *supra*, at 1827 n. 39 (citing M. Rodwin, *Medicine, Money and Morals* 140 (1993)).

risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions. [42 U.S.C. § 300e(c).]

In addition, to shield HMOs from state regulation designed to undermine their basic purposes, the HMO Act preempted "state laws which impair the formation or operation of health maintenance organizations and health service organizations." S. Rep. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3057 (referring to 47 U.S.C. §300e-10(a)).

The legislative history emphasized that Congress intended the HMO Act affirmatively to foster the growth of HMOs and to give employers and consumers an alternative to traditional fee-for-service arrangements. *Id.* at 3034. As noted in a Senate Committee Report, a principal virtue of HMOs is that they incur a financial risk in providing care and therefore have an incentive to contain costs:

The fixed price concept for comprehensive services provides a strong financial incentive to physicians, hospitals and other institutional providers of health care services to place greater emphasis on preventative services to avoid the need for costly, intensive care *which can reduce their income*. At the same time, HMO's are motivated to function more efficiently since the costs of wasteful and inefficient practices cannot be passed on to the consumer or to third party payers. [*Id.* (emphasis supplied).]

Likewise, Congress has encouraged the development of managed-care options in the Medicare and Medicaid programs. See 42 U.S.C. § 1395mm (Medicare); *id.* § 1396b(m) (Medicaid). And in the Balanced Budget Amendments of 1997, Congress further authorized Medicare to contract for health

services from risk-bearing "provider-sponsored organizations" -- entities formed by hospitals or physicians -- even if those entities do not otherwise meet the requirements of state insurance and HMO laws. See *id.* § 1395w-25.⁴

The result of the rising cost of fee-for-service health care and the above-described regulatory developments has been the rapid proliferation of HMOs and other managed-care arrangements. Numerous employers have moved away from providing health benefits under the traditional fee-for-service system and now sponsor ERISA plans which offer health-care coverage through managed-care arrangements. The issue in this case is whether a commonplace example of such a plan is unlawful under ERISA.

2(a). State Farm Insurance Company and petitioner, Health Alliance Medical Plans, Inc. ("HAMP"), entered into a contract for group health insurance.⁵ In that contract, HAMP agreed that it would arrange medical and hospital services for State Farm employees and their families through a health maintenance organization ("HMO") -- pre-paid health insurance which, for a fixed monthly payment per family or individual, provides delineated health-care coverage. Specifically, HAMP stated that it would arrange coverage "in accordance with the Subscription Certificate" through petitioner, the Carle Clinic Association, doing business as the CarleCare HMO. See Group Subscription Certificate (App. 93a) (describing CarleCare HMO

⁴ In addition, federal antitrust agencies have adopted enforcement policy statements specifically recognizing the potential benefits of physician-owned ventures for health-care consumers, particularly when the venture includes "significant financial incentives for its physician participants, to achieve specified cost-containment goals." See U.S. Dep't of Justice & Fed. Trade Comm'n, *Statement of Antitrust Enforcement Policy in Health Care* 69 (Aug. 1996) [available at <<http://www.usdoj.gov>>].

⁵ Because the courts below decided this case solely on the pleadings, petitioners' factual recitation is limited to the complaint and its attachments.

as "a health maintenance organization organized as a product of [HAMP]"). In exchange, State Farm agreed that it and its employees would pay a fixed premium for the specified coverage. *Id.* Under the contract, HAMP thus assumed the financial risk for the provision of the benefits to State Farm employees. If the cost of services were to exceed the premiums received from State Farm and its employees, HAMP would lose money on the contract. Conversely, if the cost of services were less than those premiums, HAMP would make money on the contract.

The Carle Clinic Association is a professional medical corporation owned by its physician shareholders. In addition, the Carle Clinic Association is the sole shareholder both of HAMP and another petitioner, a management entity known as the Carle Health Insurance Management Co., Inc. ("CHIMCO"). App. 4a n.3. Accordingly, the physician shareholders of the Carle Clinic Association are, collectively, also the sole shareholders of HAMP and CHIMCO.

The Group Subscription Certificate agreed to by State Farm and HAMP describes the coverage provided to State Farm employees who receive health care arranged by the CarleCare HMO. Like many other HMOs and managed-care arrangements, the CarleCare HMO contains provisions designed to contain costs, and these provisions are recited in the Group Subscription Certificate. For example, the Certificate contains explicit exclusions and limitations, including requirements that participants and beneficiaries see CarleCare HMO physicians ("Carle physicians") or other participating providers, obtain only medically-necessary treatment, and use only CarleCare-approved facilities. See *infra* at 27-28.

Respondent Cynthia Herdrich's husband was employed by State Farm, and she received health-care coverage under the CarleCare HMO. In March 1992, Herdrich's appendix ruptured

as the result of allegedly inadequate medical treatment she received from petitioner Dr. Lori Pegram, a Carle physician. As a result, on October 21, 1992, Herdrich filed a complaint against Pegram and the Carle Clinic Association in the Circuit Court of McLean County, Illinois, alleging medical malpractice. On February 18, 1994, Herdrich amended her complaint to add two state-law counts (Count III, alleging a violation of the Illinois Consumer Fraud Act, and Count IV, alleging a violation of a contractual duty of good faith and fair dealing) against all petitioners.

Petitioners removed the case to federal court, asserting that the two new counts were preempted by ERISA. Petitioners further sought summary judgment on the new claims. The district court agreed that ERISA preempted both claims. The court further granted petitioners' motion for summary judgment on Count IV. It determined that, even if Count IV were re-pled as an ERISA claim, petitioners would be entitled to summary judgment, because Herdrich was seeking monetary relief, including extra-contractual damages, which ERISA does not allow. But the court granted Herdrich "leave to submit an amended Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." App. 79a-80a.

On September 1, 1995, Herdrich filed her amended Count III. That count is the subject of the decision at issue here. In amended Count III, Herdrich alleged that petitioners breached their fiduciary duty to plan participants and beneficiaries by implementing specified cost-containment measures. She alleged that the implementation of these measures resulted in cost savings to the CarleCare HMO, thereby permitting the CarleCare HMO to earn additional income. Some part of this profit, alleged the complaint, was paid to the Carle Clinic Association's owners, the CarleCare HMO physicians, in the form of year-end "supplemental medical

expense payments." Herdrich's claim therefore was that a health-care entity (here an HMO and its physician owners) breaches a fiduciary duty under ERISA when it earns additional income by implementing cost-containment measures, even if those cost-containment measures are a feature of the plan itself.⁶

⁶ Specifically, Herdrich alleged that:

In breach of that [fiduciary] duty:

a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;

b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

(1) minimize the use of diagnostic tests;

(2) minimize the use of facilities not owned by CARLE; and

(3) minimize the use of emergency and non-emergency consultation and/or referrals to noncontracted physicians.

ii. by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is

(continued...)

Petitioners filed a motion to dismiss amended Count III pursuant to Fed. R. Civ. P. 12(b)(6). A magistrate judge was assigned to hear the case by agreement of the parties. The Magistrate Judge recommended that petitioners' motion be granted, although he also recommended that Herdrich receive one last opportunity to plead an ERISA claim. App. 64a. Herdrich objected to the magistrate judge's recommendation pursuant to Fed. R. Civ. P. 72. On April 15, 1996, however, the district court adopted the magistrate judge's recommendation of dismissal. Herdrich chose not to re-plead.

After discovery, the remaining state-law counts of Herdrich's complaint went to trial in early December 1996. The jury returned a verdict in Herdrich's favor on these state-law medical malpractice claims and awarded her \$35,000 in compensatory damages. App. 81a.

(b). Herdrich then appealed the district court's earlier dismissal of the ERISA claim in amended Count III of her complaint. In a split decision, the court of appeals reversed the judgment of dismissal. It determined that the bare allegation that petitioners implemented cost-containment measures which, if successful, would result in additional income for the HMO's owners (the Carle physicians) was sufficient to state an ERISA claim for breach of fiduciary duty.

Specifically, the court of appeals first held that petitioners "were plan fiduciaries due to their discretionary authority in deciding disputed claims." App. 14a. The court appeared (incorrectly) to believe that because petitioners were fiduciaries for this purpose, they could be characterized as

⁶ (...continued)

reasonable and customary; and
(5) whether a medical condition is an
emergency. [Complaint ¶ 12 (App. 4a
n.3).]

fiduciaries for all purposes. *Id.* The court then held that petitioners were "administer[ing]" and "manag[ing]" an ERISA plan, and thus acting as fiduciaries under ERISA section 3(21)(A), 29 U.S.C. § 1002(21)(A), when they established and implemented the cost-containment measures that were intended to produce additional income for the HMO and its owners.

In addition, the court concluded, Herdrich stated an ERISA claim for breach of fiduciary duty by alleging that petitioners implemented a mechanism that might create divided loyalties in providers of medical services:

The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. [App. 18a-19a (emphasis omitted).]

In reaching its conclusion, the court detailed its fundamental view that cost-containment mechanisms substantially erode the quality of American health care and should be eliminated. *Id.* at 24a-32a. Finally, the court of appeals held that Herdrich had adequately pled damage to an ERISA plan as a result of the breach because she alleged that HAMP, which operated the CarleCare HMO, made annual payments to its owners -- the Carle physicians -- based on the extent to which cost-containment efforts were successful. *Id.* at 38a.

Judge Flaum dissented. He observed that the complaint simply "alleges that there is a conflict of interest built into the compensation structure of the health plan in question." App. 38a-39a. He accepted "the Majority's conclusion that, taking the allegations of the complaint as true, 'an incentive existed for [petitioners] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses.'" *Id.* at 39a. But he disagreed with the majority's holding "that the mere existence of this asserted conflict, without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." *Id.* As Judge Flaum explained, "many sponsors and beneficiaries of managed care plans view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently." *Id.* at 42a-43a. Thus, "merely alleging the existence of financial incentives to limit care cannot suffice to make out a claim of breach of fiduciary duty." *Id.* at 43a.

Petitioners sought rehearing and filed a suggestion for rehearing *en banc*. The court of appeals denied the petition on March 8, 1999. App. 48a-49a. Judge Easterbrook, joined by Chief Judge Posner and Judges Flaum and Wood, dissented from denial of rehearing *en banc*. The dissenting opinion concluded that the panel's decision was wrong and that it would have widespread and damaging repercussions. *Id.* at 49a-58a.

Judge Easterbrook first observed that the premise of the panel decision is that "HMOs and other managed-care systems are inferior to available alternatives." App. 51a. This premise, as he pointed out, is at a minimum open to question:

"A[n HMO] offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, change for each procedure. Each method creates an unfortunate incentive: a physician receiving a fee for each service has an

incentive to run up the bill by furnishing unnecessary care, and an HMO has an incentive to skimp on care (once patients have signed up and paid) in order to save costs." [*Id.* (quoting *Anderson v. Humana, Inc.*, 24 F.3d 889, 890 (7th Cir. 1994)).]

Even assuming that managed care is inferior, however, Judge Easterbrook concluded that ERISA did not authorize the court to "prescribe its view of the best system" by labeling virtually all decisions implementing an HMO as fiduciary and, indeed, a fiduciary breach. *Id.*

For purposes of this case, Judge Easterbrook explained, petitioners are ERISA fiduciaries only "to the extent" that they have "discretionary authority or discretionary responsibility in the administration of [a] plan." App. 52a (quoting 29 U.S.C. § 1002(21)(A) (emphasis supplied)). And while petitioners may be ERISA fiduciaries for some purposes, they were not acting as "fiduciaries" within the meaning of ERISA when they "establish[ed] one set of cost-saving incentives rather than another." *Id.* at 53a. It is possible, Judge Easterbrook acknowledged, "to read 'in the administration of [the] plan' broadly in order to catch all discretionary elements of the HMO structure," but the result of doing so would be "to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure." *Id.* (alteration in original). The panel thus had constructively held that ERISA health-care plans "have a fiduciary duty not to adopt HMO[s] or other managed-care options," because cost-containment incentives create a conflict of interest for the health-care provider. *Id.* at 54a.

Judge Easterbrook concluded that this result made little sense. The law is clear, for example, that plan sponsors may choose "to offer an HMO as a welfare benefit," but "a plan sponsor's right to adopt an HMO plan as a benefit would not be

worth anything if implementing the HMO itself violates ERISA." App. 54a. Moreover, he observed, "[m]ost medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option." *Id.* at 56a. Accordingly, he stated, "[b]y stretching the definition of 'fiduciary' under ERISA, the panel has effectively foreclosed a popular option for the delivery of medical care and taken the decision out of private hands, to which ERISA committed it." *Id.* at 54a.

Nor could the results of the panel's decision be cabined, "for the plan attacked in this case is an ordinary HMO":

If Carle's setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." [App. 56a-57a.]

Finally, Judge Easterbrook pointed out that even assuming that petitioners were acting as fiduciaries, the panel's holding -- that a bare allegation that an HMO employs cost-containment incentives states a claim for breach of fiduciary duty -- would have significant, damaging consequences: "[T]he panel's opinion puts all managed-care systems at risk and commits the court to a long (and I should think unhappy) course of distinguishing 'good' managed-care systems from 'bad' ones." App. 58a. These judgments, he stated, belong to

Congress or to plan sponsors and participants, and ERISA should not be used "to impress a different view of desirable medical care on employers and HMOs alike." *Id.*

This Court granted the petition for certiorari on September 28, 1999.

SUMMARY OF ARGUMENT

In the decision below, the court of appeals held that an HMO and its physicians act as fiduciaries under ERISA when those physicians receive financial incentives to provide medical care to the HMO's members in a cost-effective manner. The court further held that the bare allegation that an HMO has adopted such cost-containment features (as numerous health plans have) states a claim for breach of fiduciary duty under ERISA. Thus, the court of appeals effectively held that under ERISA, employers "have a fiduciary duty not to adopt HMO[s] or other managed-care options." App. 54a (Easterbrook, J., dissenting). ERISA imposes no such duty. The decision below should be reversed.

The court of appeals decided that petitioners were fiduciaries with respect to all discretionary decisions involved in the provision of health care to State Farm employees and their families. ERISA, however, imposes fiduciary obligations only "to the extent" that a person is exercising discretion in performing certain defined functions such as "administer[ing] or manag[ing]" an employee pension or welfare benefit "plan." 29 U.S.C. § 1002(21)(A) (emphasis added). When that person is engaged in *other* activities that involve the exercise of discretion, he or she is not acting as a fiduciary, even if the exercise of that discretion would substantially affect the plan. See *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890-91 (1996).

Petitioners were not engaged in any of the activities that trigger ERISA's fiduciary obligations when they implemented the cost-containment mechanism at issue here.

1. When it established its employee welfare plan, State Farm made plan-design decisions that called for the cost-containment measures, thus placing these measures outside of ERISA's fiduciary realm. Specifically, State Farm decided to "establish[]" and "maintain[]" its welfare benefit plan by purchasing memberships in the CarleCare HMO for its employees. See 29 U.S.C. § 1002(1). The sole plan benefit either established or maintained by the employer, therefore, was *membership* in the HMO, and only decisions about that specific benefit are fiduciary in nature. Accordingly, the CarleCare HMO was not making decisions about a benefit provided in an ERISA plan when it made internal, discretionary decisions in its provision of health care to members, including State Farm employees, and was not subject to ERISA's fiduciary standards. See Part I.A.1.

2. Even assuming, as petitioners do for the remainder of the brief, that the benefits provided by the State Farm plan are the particular medical services defined in the Group Subscription Certificate, State Farm's decision to provide health-care benefits through the CarleCare HMO was a plan-design decision not subject to ERISA's fiduciary standards. ERISA does not forbid an employer to select an HMO or other managed-care arrangement to provide health-care benefits to its employees. See *Hughes*, 119 S. Ct. at 763-64; *Lockheed*, 517 U.S. at 887. An HMO is, by definition, an entity that assumes "full financial risk on a prospective basis for the provision of basic health services," 42 U.S.C. § 300e(c)(2), and, as such, is financially motivated to contain costs. A plan sponsor's decision to provide health-care benefits through an HMO is therefore a plan-design decision that necessarily entails the implementation of cost-containment measures. And it cannot

be a fiduciary violation to *follow* the terms of the plan design, which is all that was alleged here. See Part I.A.2.

3. State Farm's decisions about plan design clearly rendered petitioners' implementation of the cost-containment mechanism at issue not subject to fiduciary duties. But even if they had not, petitioners' implementation of the mechanism nonetheless was not fiduciary in nature. As noted, an entity is a fiduciary only "to the extent" that it exercises discretionary authority in the "administration" or "management" of a plan. HMOs and other health-care providers make myriad discretionary decisions in arranging for health care for members, including its members who are participants in an ERISA plan. Many such judgments -- including the cost-containment mechanisms adopted -- have no direct impact on the benefits provided by an ERISA plan. Numerous HMO decisions -- *e.g.*, a decision to require pre-approval by the plan of hospital admissions -- might in a particular case be said to result in a reduction in the quality of benefits under a plan or affect a provider's judgment about when and where an enrollee should receive medical services. But it simply makes no sense to characterize as fiduciary all ordinary business judgments in any way connected with arranging health care under a plan.

Indeed, Herdrich's argument -- that the statutory definition of fiduciary conduct as discretionary decisions in the "administration" and "management" of an ERISA plan should be expanded to include decisions that have only an *indirect* impact on plan benefits -- cannot be squared with the structure of ERISA or this Court's precedent. There are numerous provisions in ERISA where Congress makes an explicit distinction between "direct" and "indirect" actions, including aspects of the definition of fiduciary that are *not* relied upon by Herdrich. See 29 U.S.C. § 1002(21)(A)(ii) (defining a fiduciary to include a person that "renders investment advice for a fee or other compensation, *direct or indirect*, with respect to any

moneys or other property of [an ERISA] plan"). See also *id.* §§ 1002(14), 1106(a), 1112. Congress pointedly did not characterize as fiduciary "direct or indirect" administration or management of an ERISA plan and, indeed, narrowed the common law scope of fiduciary responsibility under ERISA. This Court should reject Herdrich's invitation to read such language into the definition of fiduciary.

In addition, in the analogous area of ERISA preemption, this Court has held that state laws which have an *indirect* economic impact on ERISA plans and which may therefore *indirectly* affect plan administration do not "relate to" an ERISA plan and thus are not preempted. See *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997); *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 659-60 (1995). If an act having an indirect economic influence on plan administration does not "relate to" an ERISA plan, *a fortiori*, a judgment that only potentially has an indirect economic influence on a plan benefit cannot be deemed to constitute "management" or "administration" of a plan.

Herdrich's expansive reading of "fiduciary" is flawed for several additional, independent reasons. It is well established that this Court will not "lightly" infer that "Congress has derogated state regulation, but instead ha[s] addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law." *Travelers Insurance Co.*, 514 U.S. at 654. But if, as Herdrich maintains, medical and business judgments with only an indirect impact on plan benefits are deemed acts of plan administration or management and thus are fiduciary, then *any* state law claim based on such judgment necessarily "relate[s] to" an ERISA plan and is preempted. See 29 U.S.C. § 1144(a). Herdrich's reading of the act would also bring ERISA into square conflict with Congress' explicit authorization and approval of managed-

care arrangements. For example, in the HMO Act, Congress expressly authorized and approved the use of HMO arrangements for health-care delivery and preempted state laws designed to impede the emergence of HMOs. See 42 U.S.C. §§ 300e, 300e-10(a). Similarly, Congress has expressly encouraged the development of managed-care options in Medicare and Medicaid programs. See *id.* §§ 1395mm, 1396b(m). See Part I.B.

4. Even if petitioners' implementation of the cost-containment mechanism at issue were a fiduciary act, Herdrich's Complaint would fail to state a claim for breach of fiduciary duty. Herdrich asserts only that adoption of a cost-containment mechanism that gives an HMO or an HMO physician divided loyalties -- to patient/beneficiaries on the one hand and to financial gain on the other -- is inherently a breach of fiduciary duty. That is not the law under ERISA. To the contrary, ERISA expressly permits the same person or entity to act as a fiduciary in one context and in service of self-interest in another. See, e.g., *Hughes*, 119 S. Ct. at 763; *Lockheed*, 517 U.S. at 890-91. Here the business judgments that help to shape the design of a health-care plan may be made with cost containment in mind, while benefit eligibility and delivery decisions must be made with fiduciary loyalty. Far from violating ERISA, this duality is contemplated by ERISA's definition of fiduciary. See Part II.

5. Finally, any doubt that Herdrich has failed to state a claim for breach of fiduciary duty is made plain by her failure to allege cognizable damage to an ERISA plan. According to Herdrich, "the plan" was injured by the year-end financial distribution from HAMP to its owners, the Carle physicians. This argument necessarily assumes that the CarleCare HMO included a trust fund for the benefit of plan members and that these financial distributions were part of the corpus of a trust intended to benefit the members of the CarleCare HMO. State

Farm, however, established no such trust and none is alleged. Rather, the benefit provided by the CarleCare HMO is "arrang[ing] for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate." App. 93a. Thus, Herdrich's Complaint fails to allege any damage to an ERISA plan because the money paid to HAMP under its contract with State Farm was not part of any plan trust and the payment of some portion of that money to HAMP's owners did not deprive plan participants of any benefit promised by the CarleCare HMO. See Part III.

ARGUMENT

ERISA "comprehensively regulates employee pension and welfare plans." *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). An "employee welfare plan" is:

any plan, fund or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits . . . [29 U.S.C. § 1002(1).]

ERISA requires that employee welfare-benefit plans be established pursuant to a written instrument, *id.* § 1102(a)(1), and imposes a number of procedural standards concerning reporting, disclosure, and fiduciary responsibility, *id.* §§ 1021-31, 1101-14.⁷ ERISA also preempts state laws "insofar as they may now or hereafter relate to any employee benefit plan." *Id.* § 1144(a). However, "[n]othing in ERISA requires employers

⁷ Unlike pension plans, ERISA does not establish any "minimum participation, vesting, or funding requirements for welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

to establish employee benefits plans. . . . [n]or does ERISA mandate what kind of benefit employers must provide if they chose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). See also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Alessi v. Raybestos-Manhattan, Inc.* 451 U.S. 504, 511 (1981).

It is ERISA's fiduciary responsibilities that are at issue in this case. Congress required plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104. Congress, however, recognized that it would be ultimately self-defeating to impose such fiduciary duties too broadly. Potentially "every business decision an employer makes can have an adverse impact on [an ERISA] plan" and businesses would naturally be extremely reluctant to offer such plans if doing so would require them to run their business for the sole benefit of the plan participants. *Varity Corp. v. Howe*, 516 U.S. 489, 527 (1996) (Thomas, J., dissenting). Thus, Congress made clear that "ERISA does not require that 'day-to-day corporate business transactions, which may have a collateral effect on prospective, contingent employee benefits, be performed solely in the interest of plan participants.'" *Adams v. Avondale Indus., Inc.*, 905 F.2d 943, 947 (6th Cir. 1990). Rather, "only when fulfilling certain defined functions, including the exercise of discretionary authority or control over plan management or administration, does a person become a fiduciary" under ERISA. *Lockheed*, 517 U.S. at 890 (citing 29 U.S.C. § 1002(21)(A)).⁸

⁸ A person is also a fiduciary to the extent "he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so." 29 U.S.C. § 1002(21)(A). That provision is not at issue in this case.

By purchasing memberships in the CarleCare HMO for its employees, State Farm "established and maintained" an "employee welfare benefit plan" subject to ERISA. As set forth below, petitioners did not breach any fiduciary duty with respect to this ERISA plan when they implemented the cost-containment mechanism at issue here, and nothing in ERISA precludes the delivery of health-care benefits through such a managed-care arrangement.

I. AN HMO AND ITS PHYSICIANS DO NOT ACT AS FIDUCIARIES BY IMPLEMENTING COST-CONTAINMENT INCENTIVES.

The court of appeals held that petitioners were acting as fiduciaries when they implemented a cost-containment mechanism that financially rewards physicians for successfully containing costs while providing health care under the CarleCare HMO plan. Under ERISA,

a person is a fiduciary with respect to a plan *to the extent* (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. [29 U.S.C. § 1002(21)(A) (emphasis supplied).]

A person is a fiduciary only "to the extent" that he or she is engaged in one of the defined activities. It follows therefore that when that person is engaged in other activities that involve

the exercise of discretion, he or she is not acting as a fiduciary, even though that exercise of discretion may substantially affect the plan. Thus, for example, an employer is not acting as a fiduciary when it selects a plan's terms or modifies or terminates the plan, even though that same employer is a fiduciary when administering the plan. See, e.g., *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996).

The court of appeals appears to have believed that petitioners can be characterized as ERISA fiduciaries for all purposes if they are ERISA fiduciaries for any purpose. See, e.g., App. 14a ("[w]e can reasonably infer that [petitioners] were plan fiduciaries due to their discretionary authority in deciding disputed claims"). That position is flatly contradicted by this Court's holdings in *Hughes* and *Lockheed*. This fundamental error appears to be the basis for the court of appeals' conclusion that petitioners have "discretionary authority or discretionary control respecting management of [the] plan" and "discretionary authority or discretionary responsibility in the administration of [the] plan." App. 12a. The critical question, however, is not whether petitioners are *ever* ERISA fiduciaries, but whether petitioners were acting as fiduciaries with respect to an ERISA plan when they implemented measures to contain costs and earn additional income for the HMO and its owners. They were not.

**A. State Farm's Plan Design Decisions
Rendered Petitioners' Implementation Of
The Cost-Containment Mechanism At Issue
Not Subject To Fiduciary Duties.**

1. *Petitioners' Implementation of the Cost-Containment Mechanism At Issue Does Not Affect The Sole Benefit Offered Under the State Farm "Employee Welfare Plan."* In this case, the plan sponsor, State Farm, made the lawful choice to establish and maintain an ERISA plan that provides health-care benefits by purchasing memberships in the CarleCare HMO for its employees. As noted, an ERISA "plan" is *only* the "plan, fund, or program" that is "*established or maintained by [the] employer.*" See 29 U.S.C. § 1002(1) (emphasis supplied). The sole benefit in the plan "established or maintained by [the] employer" here is *membership* in the CarleCare HMO. *Id.* Accordingly, the "plan" here consisted of (a) State Farm's provision of membership in the CarleCare HMO; (b) State Farm's designation of beneficiaries (*i.e.*, the group of employees entitled to receive that benefit); (c) State Farm's obligation partially to finance employees' membership in the CarleCare HMO; and (d) State Farm's procedure for employees to elect (or appeal the denial of) membership in the CarleCare HMO. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (explaining that a "plan" consists of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits).

After the State Farm plan was established, State Farm's discretionary decisions that related to individual employees' membership in the HMO became fiduciary in nature because they determined whether the employee would receive the benefit under State Farm's ERISA plan (*viz.*, the right to membership in the HMO). But the CarleCare HMO itself was not "established" and is not "maintained" by the "employer" (State Farm), and so the CarleCare HMO's internal decisions

about the arrangement or provision of health care to its members are not decisions about a benefit offered under an ERISA "employee welfare plan." As Judge Easterbrook put it:

if . . . one conceives of the Carle Care HMO system as the benefit promised by the ERISA plan, then Carle is not a "fiduciary." It is just the supplier of medical care, like the surgeon [deciding how (if at all) to perform an operation]. . . . Herdrich does not allege that State Farm hired Carle to administer a medical plan that offers defined medical procedures as benefits; she alleges, rather, that the benefit State Farm offered is the CarleCare HMO system. . . . [T]o the extent there is uncertainty about the right way to characterize Carle's role, the court should prefer the characterization that preserves plan sponsors' (and participants') freedom of choice. That means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan. *If the HMO system is the benefit, then Carle is not acting as a fiduciary.* [App. 55a-56a (emphasis supplied).]

Because membership in the CarleCare HMO is the sole benefit under the State Farm "plan," the HMO's internal, discretionary decisions about the provision of health care for a member -- be it the HMO's decision that a particular treatment is experimental, a Carle physician's decision that a particular treatment is not warranted, or an HMO employee's decision that a member is not entitled to reimbursement for care outside of the HMO's service area -- do not constitute "administ[ration]" or "manage[ment]" of an "employee welfare plan" and are not subject to ERISA's fiduciary standards. Indeed, the CarleCare HMO's role with respect to its members

who are State Farm employees differs not one iota from its role with respect to those who are not. The HMO is arranging health care, not making fiduciary judgments with respect to a benefit under an ERISA plan. For this reason alone, the court of appeals' decision that petitioners were acting as fiduciaries should be reversed.

2. *The Cost-Containment Mechanism At Issue Is A Matter of Plan Design Not Subject to ERISA's Fiduciary Standards.* For the rest of the brief, petitioners assume that the benefits under the State Farm plan are the particular medical services specified in the Group Subscription Certificate. Even if that is so, State Farm's decision to arrange health-care benefits through the CarleCare HMO was a plan-design decision not subject to ERISA's fiduciary standards. See *Lockheed*, 517 U.S. at 890-91; *Hughes*, 119 S. Ct. at 763-64. Equally clearly then, neither State Farm nor petitioners were acting as fiduciaries when they agreed to provide benefits through a plan which expressly included cost-containment measures designed to reduce the HMO's costs and increase its earnings.

The plan-design decision to provide benefits through an HMO is significant here. The plan benefits at issue are not simply the health-care services enumerated in the Group Subscription Certificate divorced from the exclusions and the limitations also set forth therein. Under the State Farm plan, Herdrich was entitled to the health-care coverage provided by the Carle Clinic HMO. See Group Subscription Certificate (App. 93a) ("CarleCare HMO agrees to arrange for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate"). An HMO is, by definition, an entity that assumes "full financial risk on a prospective basis for the provision of basic health services, except that a[n] HMO may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume

all or part of the financial risk . . . for the provision of basic health services. . . ." 42 U.S.C. § 300e(c)(2). The chief attraction of such entities, according to Congress, is that they are financially motivated to contain costs. See S. Rep. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3047. A plan sponsor's decision to provide health-care benefits through an HMO is therefore a plan-design decision which necessarily entails the implementation of cost-containment measures designed to reduce costs and increase earnings for the HMO and its owners.

That is precisely the decision State Farm made here. It entered into an agreement which provided that State Farm employees would receive health-care benefits arranged by the CarleCare HMO. The CarleCare HMO bore the financial risk arising out of the arrangement of health-care services to State Farm employees and their families who became members. It therefore implemented measures which encouraged physicians and other individual providers to contain costs, which, when successful, resulted in additional net income for the HMO and its owners. Herdrich's claim that petitioners breached their fiduciary duty by doing so is, at bottom, nothing more than a claim that it is a fiduciary breach to provide health-care benefits through an HMO.

It is evident on the face of the principal plan document here -- the Group Subscription Certificate -- that the CarleCare HMO had cost-containment measures in place. Indeed, each cost-containment measure which Herdrich cited as part of the fiduciary breach is expressly recited in the Group Subscription Certificate. Specifically, Herdrich alleged a breach of fiduciary duty in HAMP's and CHIMCO's agreement with the Carle Clinic Association to "minimize the use of diagnostic tests," minimize the use of non-CarleCare HMO facilities, and minimize the use of consultations and referrals to "non-contracted physicians." Complaint ¶ 12(b)(1)(1) (App. 86a).

The Group Subscription Certificate establishing Herdrich's health-care benefits itself stated that "[d]iagnostic and treatment services by non-CarleCare Physicians were provided only when referred by the Primary Care Physician," and required "prior written authorization from the CarleCare Medical Director" except in emergencies, as defined elsewhere in the Group Subscription Certificate. Section 7.2 (App. 111a). It further provided that, except in defined emergencies, "[c]are by Physicians, other than CarleCare Physicians or Providers, or in hospitals not associated with CarleCare" was "NOT covered by CarleCare." Section 8.1 (App. 118a). Similarly, the Group Subscription Certificate required that "X-ray and laboratory tests and services" be approved by the Medical Policy Committee and explained that they were "covered [only] when Medically Necessary" and "obtained at an approved CarleCare facility." Section 6.5 (App. 103a).

Herdrich also alleged that HAMP sought to reduce costs by determining the CarleCare HMO's coverage, the CarleCare HMO's applicable standard of care, which proposed treatments were experimental, whether certain treatments were reasonable and customary, and whether an emergency existed. Again, the General Subscription Certificate explicitly indicated that these common place cost-containment measures were in effect. See Section 6 (App. 102a) (defining "service schedule" and explaining that services were provided "subject to the Limitations and Exclusions . . . and in accordance with accepted medical and surgical practices and standards approved by the Medical Policy Committee of CarleCare in conjunction with the Primary Care Physician"); Section 1.14 (App. 95a) (defining "[m]edically [n]ecessary"); Section 6.18 (App. 107a) (defining "[e]mergency [m]edical [c]are"); Section 8 (App. 118a) (defining "[e]xclusions," including the exclusion for services not medically necessary).

The cost-containment measures Herdrich cited in support of her claim for fiduciary breach thus were, in terms, elements of the CarleCare HMO's design. Herdrich's only further allegations were (a) that the owners of the HMO had a financial incentive to contain costs in order to earn additional income, and (b) that the owners of the CarleCare HMO were the CarleCare HMO physicians. Neither of these allegations removes her claim from the realm of plan design.

With respect to the first, a decision to utilize an HMO or other managed-care organization is a plan-design decision to accept a care provider motivated to contain costs in order to earn additional income. See 42 U.S.C. § 300e(c); *supra* at 4-5. A primary goal and a necessary consequence of effective cost containment is earnings for the HMO:

If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." [App. 57a (emphasis supplied).]

With respect to the second, it makes no "legal (or practical) difference" that the CarleCare HMO is owned by its physicians. App. 57a. All HMO owners have a financial incentive to contain costs and to earn additional income. Physician owners are not more likely than corporations or other HMO owners to pursue cost containment at the expense of patient welfare. Indeed, physicians' decisions concerning

patients are governed by professional medical codes, see American Medical Ass'n, *Code of Medical Ethics* (1998-99), and the law of medical malpractice, so physician owners of HMOs are substantially *less* likely than corporate owners of HMOs to make medical and business judgments solely on the basis of their financial interest. See also E. Hirshfeld, *The Case for Physician Direction in Health Plans*, 3 *Annals of Health Law* 81, 92 (1994). Moreover, as Judge Easterbrook pointed out, the effect of any particular medical decision on the income of an HMO owner, including a physician owner, is "minuscule." App. 57a.

In sum, ERISA does not forbid an employer to select an HMO or other managed-care arrangement to provide health-care benefits to its employees. State Farm, the plan sponsor, decided to provide health-care benefits to its employees through the CarleCare HMO. The Group Subscription Certificate on its face contained all of the measures which Herdrich cited as fiduciary breaches in her Complaint -- measures plainly designed to encourage cost containment and to increase the earnings of the HMO and its owners. In addition, and of critical importance here, that consequence was inherent in the decision to provide benefits through an HMO. It simply cannot be a fiduciary violation to *follow* the terms of a plan which is all that is alleged here. See also 29 U.S.C. § 1104(a)(1)(D) (requiring a fiduciary to act "in accordance with the documents and instruments governing the plan"). Herdrich's claim that petitioners breached their fiduciary duty by implementing cost-containment measures in order to earn additional income for the HMO thus seeks to apply ERISA's fiduciary standards to a plan-design decision and, for that reason alone, should be dismissed.

B. Even Assuming That Implementation Of Financial Incentives For Cost-Containment Is Not A Plan Design Decision, Petitioners' Implementation Of Such Incentives Is Not Fiduciary In Nature.

1. In her amended Count III, Herdrich did not claim that she has been denied a plan benefit as defined by ERISA. Such an allegation plainly would state a claim under ERISA. Instead, she asserted that the CarleCare HMO had in place a practice or policy (the cost-containment measures and the year-end financial distributions to CarleCare HMO physicians) that gave CarleCare HMO administrators and physicians a financial incentive to limit care. She further claimed that this practice or policy might indirectly result in incorrect decisions about plan benefits. She maintained that HMOs are "administer[ing]" or "manag[ing]" an ERISA "plan" when they implement business and medical policies, practices, and judgments that have an *indirect effect* on plan benefits. Finally, she alleged, the implementation of the policy or practice at issue here was a *fiduciary breach* because it *might indirectly affect* benefits by inducing HMO administrators and physicians not to provide treatment or to provide lower-quality treatment.

As noted several times, ERISA's definition of "fiduciary" provides that institutions and individuals are fiduciaries "to the extent" they have discretionary authority in the "management" or "administration of [an ERISA] plan." 29 U.S.C. §1002(21)(A). This definition has not previously been, and should not now be, interpreted so expansively as to embrace any act or decision by a health-care provider that may indirectly affect benefits provided under an ERISA plan. Specifically here, petitioners' implementation of financial incentives for physicians to contain the costs of providing health-care benefits under a plan was not a fiduciary act,

because it did not involve "administration" or "management" of an ERISA "plan."

State Farm established an ERISA plan for its employees by purchasing for them memberships in the CarleCare HMO. The HMO was not itself an ERISA plan, but it played important roles in connection with the plan. If the plan benefits are the particular medical services in the Group Subscription Certificate, then the CarleCare HMO was acting as the administrator of an ERISA plan when it took action that directly affected participants' entitlement to benefits under the plan (e.g., when a CarleCare HMO administrator denied or granted a claim for benefits under the plan). But see Part I.A.1., *supra*. In addition, the HMO arranged for medical care for its subscribers, including ERISA plan participants. When performing this role, the HMO made numerous business and medical decisions that might indirectly have affected plan benefits.⁹

An HMO is a plan fiduciary within the meaning of ERISA only when it is administering the plan, *i.e.*, only when making decisions and taking actions which directly affect an individual participant's entitlement to plan benefits. It is not administering the plan -- and thus is not a fiduciary -- when in the course of providing or arranging for medical care, it makes business and medical decisions which have only an indirect effect on plan benefits. If the concept of plan administration and management were expanded to embrace all decisions which indirectly affect benefits, virtually all decisions affecting an ERISA plan would implicate fiduciary responsibilities, would be regulated by federal law, and could be litigated in federal court. Cf. *New York Conference of Blue Cross & Blue Shield Plans v.*

⁹ An HMO is also the insurer of the health care benefits promised by the employer. Congress expressly preserved most state regulation of the business of insurance in section 514(b)(2) of ERISA, 29 U.S.C. § 1144(b)(2).

Travelers Insurance Co., 514 U.S. 645, 655 (1995) ("[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere'" (quoting H. James, *Roderick Hudson*, xli (New York ed., World's Classics 1980) (second alteration in original))).

Most plainly, under Herdrich's theory, all discretionary medical judgments -- from the medical policy judgment that certain treatments are experimental to individual physician judgments involving the need for treatment and its substance and timing -- would constitute acts of plan administration and thus fiduciary judgments subject to ERISA. As a result, all of an HMO's medical professionals, from its Medical Policy Committee to individual physicians, would be subject to ERISA's fiduciary standards (and not state law) each time they made a discretionary decision which indirectly affected health-care benefits.

In addition, health-care institutions and professionals who provide benefits under ERISA plans make numerous business policies and judgments that may indirectly affect health-care benefits. For example, all businesses, including health-care providers, seek to control costs; virtually any cost-saving decision may indirectly affect benefits. When a managed-care organization decides to pay hospitals a set fee per in-patient admission, regardless of the patient's length of stay, that arrangement financially rewards the hospital for treating a large number of patients and discharging them as quickly as possible. HMOs may restrict care, refuse to cover certain kinds of therapies, discipline or fail to promote physicians and other providers who fail to contain costs, or financially reward physicians and other health-care providers for containing costs. Such decisions inherently involve a careful balancing of business and clinical considerations and may indirectly affect benefits.

On Herdrich's and the court of appeals' theory, all such decisions are fiduciary in nature and subject to ERISA, and thus courts must decide whether they have been made with an "eye single" to the interests of participants. See *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (Friendly, J.). This outcome is entirely inconsistent with the structure of ERISA. In ERISA, Congress narrowed the scope of fiduciary obligations found in the common law of trusts. For example, ERISA trustees, unlike common law trustees, may possess dual loyalties and, indeed, may act in furtherance of their conflicting interests outside of the fiduciary realm. See 29 U.S.C. §1002(21)(A) (a person is an ERISA fiduciary only "to the extent" that he or she is engaged in certain types of acts); *Varity Corp. v. Howe*, 516 U.S. 489, 498 (1996) (an ERISA trustee may have and act on dual loyalties). But if the fiduciary realm expands beyond decisions that directly affect benefits to embrace all decisions that indirectly affect benefits, most business and medical judgments made in providing health-care benefits under an ERISA plan will be deemed fiduciary, and Congress' deliberate attempt to limit the area of application of ERISA's fiduciary standards will be frustrated. Cf. *id.* at 539 (Thomas, J., dissenting) (explaining that an employer is not acting as a fiduciary simply "because an ordinary business decision turn[ed] out to have an adverse impact on the plan").¹⁰

Herdrich's argument -- that the statutory definition of fiduciary conduct as discretionary decisions in the "administration" and "management" of an ERISA plan should be expanded to include decisions that have only an indirect

impact on plan benefits -- is inconsistent with another important aspect of ERISA's structure. There are numerous provisions in ERISA where Congress makes an explicit distinction between "direct" and "indirect" actions. Indeed, in the definition of fiduciary, Congress states that a party that "renders investment advice for a fee or other compensation, *direct or indirect*, with respect to any moneys or other property of [an ERISA] plan" is a fiduciary. 29 U.S.C. § 1002(21)(A)(ii) (emphasis added). See also *id.* § 1002(14) (making certain "direct or indirect" owners "parties in interest"); *id.* § 1106(a) (making certain "direct or indirect" transactions illegal); *id.* § 1112 (prohibiting ERISA fiduciaries from procuring a bond from parties that have "direct or indirect" financial relationships with the plan). Congress pointedly did not characterize as fiduciary "direct or indirect" administration or management of an ERISA plan, and this Court should reject Herdrich's invitation to read such language into the definition of fiduciary.

In the closely analogous area of ERISA preemption, this Court has twice recently held that state laws which have merely an *indirect* economic impact on ERISA plans and which may therefore *indirectly* affect plan administration do not "relate to" an ERISA plan and thus are not preempted. In *Travelers Insurance Co.*, this Court explained that it was unwilling to preempt a state law which had only an "indirect economic influence" on plan administrators, relying on the State's strong and traditional interest in regulating the provision of health care. See 514 U.S. at 659 ("[a]n indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself"); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997) (a state law which "increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans," but nonetheless

¹⁰ Perhaps the courts could somehow limit the expansive reach of Herdrich's interpretation of "fiduciary," by considering how substantial an indirect effect on plan benefits or administration is required before a business or medical judgment is deemed fiduciary. Under such a fact-specific test for fiduciary status, however, the extent of "fiduciary" responsibility would become even more ill-defined.

does not "relate to" an ERISA plan).¹¹ If an act having an indirect economic influence on plan administration does not "relate to" an ERISA plan, it follows that a judgment that only potentially has an indirect economic influence on a plan benefit should not be deemed to constitute "management" or "administration" of a plan.

In this case, participants and beneficiaries covered by the State Farm plan were entitled to the health-care benefits set forth in the Group Subscription Certificate. Herdrich did not -- and could not -- allege that petitioners had in place a cost-saving mechanism, policy or practice that altered the terms of the plan or directly deprived a participant of benefits provided by the plan. (Quite to the contrary, as the amended complaint and the attached Group Subscription Certificate reflect, *the cost-saving features that Herdrich objected to are embodied in the terms of the plan itself*.) Accordingly, the cost-containment mechanism of which Herdrich complained was the product of a business and medical decision, not a decision about a plan benefit. And, although that decision may potentially have had an indirect effect on the provision of benefits (the health-care services provided by the CarleCare HMO), petitioners were not engaged in plan administration or management when they made it.

2. Herdrich's broad interpretation of ERISA's definition of "fiduciary" is inconsistent with the Act in another way: It would substantially expand ERISA's already significant preemptive effect on state law. As this Court has stated, nothing in ERISA or its legislative history suggests any express

¹¹ Cf. *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (holding that California's prevailing wage law is not preempted by ERISA); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 838-41 (1988) (explaining that a law operating as merely an indirect source of economic influence on administrative decisions should not suffice to trigger preemption).

congressional desire to preempt general state regulation of the provision of health care. Hence, this Court has "never assumed lightly that Congress has derogated state regulation, but instead ha[s] addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law." *Travelers Insurance Co.*, 514 U.S. at 654 (citing *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)). Indeed, where it is said that federal law displaces "state action in fields of traditional state regulation, [the Court has] worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* at 655 (citation omitted) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Indeed, this Court has already explained that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661 (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985)). Herdrich's proposed interpretation of "fiduciary," however, would broadly preempt state law in this area of traditional local concern. ERISA preempts any state law that "relate[s] to" an ERISA plan. See 29 U.S.C. § 1144(a). The more expansively ERISA defines "fiduciary," the more conduct traditionally regulated by the state will be preempted by and subject to ERISA. If medical and business judgments with an indirect impact on plan benefits are deemed acts of plan administration or management and thus fiduciary under federal law, then any state law tort claim, including a medical malpractice claim, based on such a judgment necessarily "relate[s] to" an ERISA plan. On Herdrich's theory, most medical or business judgments are acts of plan

administration or management, and any state law regulation of these judgments is preempted by ERISA.¹²

Absent some express indication that Congress intended such preemption to occur, this Court has refused to interpret ERISA to deprive the States of their traditional power to regulate the provision of health care. This Court has carefully cabined the definition of the phrase "relate to" to prevent such an impingement; for similar reasons, the definition of "administration" and "management" ought likewise to be confined. Indeed, Herdrich's broad construction would result in virtually the same sweeping preemptive effect on state laws affecting health care that this Court disapproved in *Travelers Insurance Co.* For this reason, too, ERISA's definition of fiduciary should not be interpreted to sweep in business and medical policies, practices, and judgments that only potentially and indirectly affect a participant's right to receive a benefit under an ERISA plan, such as an HMO's decision to implement a particular cost-containment mechanism.

3. Herdrich's expansive reading of ERISA is also wrong because it unnecessarily brings ERISA into conflict with Congress' explicit authorization and approval of managed-care

¹² In an effort to avoid such preemption, the courts of appeals struggle to distinguish plan administration from the arrangement or provision of medical care. There are a number of court of appeals decisions addressing whether discretionary medical policies, practices, and judgments are acts of plan administration. See, e.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352-53 (3d Cir. 1995); *Pacificare, Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 272-73 (2d Cir. 1994); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1329 (5th Cir. 1992). There appears to be general agreement that only allegations that a participant has been denied a plan benefit should be considered preempted under ERISA, but the courts are plainly divided about how to determine when a claim addressed to medical care is a claim that a plan benefit has been denied (and thus preempted by 29 U.S.C. § 1132(a)) or a claim that "relate[s] to" a plan (and thus preempted by 29 U.S.C. § 1144).

arrangements. Her interpretation of ERISA's definition of "fiduciary" would derail virtually any attempt to implement cost-containment strategies. If business and medical policies, practices, and judgments which might indirectly affect benefits under an ERISA plan are fiduciary, then a fiduciary breach occurs virtually any time a health-care provider implements a cost-containment mechanism. See *supra* at 26-27.¹³ The legislative history of ERISA contains no suggestion that Congress intended to preclude managed-care arrangements, and ERISA should not be interpreted to have that consequence. See ERISA section 514(d), 29 U.S.C. § 1144(d) ("Nothing in this subchapter [ERISA] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States [except where expressly indicated], or any rule or regulation issued under any such law.").

As described above, Congress passed the HMO Act in 1972 to encourage the growth of HMOs. By statutory definition, HMOs assume the financial risk of providing health care and are expressly authorized to place some of that financial risk on physicians and other health-care professionals providing services. See *supra* at 4-5. Congress has also encouraged the implementation of managed-care options in the federal

¹³ As Judge Easterbrook stated:

[W]hy should courts do this? In order to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure (or that participants will select it from among options the plan offers)? The panel's opinion sounds very much like this is the objective: its lengthy condemnation of managed care, 154 F. 3d 373-79, otherwise is hard to understand. [App. 53a.]

Medicare and Medicaid programs. See 42 U.S.C. §§ 1395mm, 1396b(m), 1395w-25.¹⁴

These initiatives demonstrate a congressional commitment to development of alternative health-care delivery systems and to the direct financial participation of physicians and other health-care providers in those systems. More directly to the point, they provide an important reason that federal courts should not expand ERISA's definition of "fiduciary" to make unlawful the type of health-care organization that Congress has promoted as an alternative to traditional fee-for-service arrangements. See *Morton v. Mancari*, 417 U.S. 535, 551 (1974) ("when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective").

4. Finally, extant federal and state regulation -- and the ever-increasing public and legislative interest in the issues raised by managed care -- demonstrate that there is no need artificially to expand ERISA in order to address these issues. As set forth *supra* at 4-5, Congress has already enacted general legislation governing managed care, as well as legislation addressed to managed-care issues in the setting of federal programs. Additional federal legislation is actively being contemplated. In addition, numerous States have enacted HMO laws, including those specifically addressing managed-care arrangements that may have an impact on the quality of care.¹⁵ This type of state

¹⁴ See also 42 C.F.R. § 417.479 (addressing financial incentives in the Medicare and Medicaid contexts).

¹⁵ See, e.g., Me. Rev. Stat. Ann. tit. 24-A, §§ 2671-2676 (Maine); N.Y. Pub. Health Law §§ 4400-4413 (New York); N.D. Cent. Code §§ 26.1-18.1-01 to -25 (North Dakota); Pa. Stat. Ann. tit. 40, §§ 1551-1568 (Pennsylvania); Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-.003 (Texas) (upheld in part, *Corporate Health Insurance Inc. v. Texas Dep't of Insurance*, 12 F. Supp. (continued...)

regulation has not been deemed preempted except where the court concludes that it has mandated particular employee-benefit structures or specific aspects of plan administration.¹⁶ Indeed, state regulation of certain cost-containment mechanisms, such as capitation agreements and other financial arrangements between HMOs and providers, may be expressly saved from ERISA preemption as laws governing the business of "insurance." 29 U.S.C. § 1144(b)(2). See also *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 741-47 (1985); Carol L. O'Brien, *Direct Contracting: Potential Legal and Regulatory Barriers*, 79 Minn. Med. 21, 23 (1996) (discussing National Association of Insurance Commissioners, Draft White Paper on the Regulation of Risk-Bearing Entities (Sept. 25, 1996)).

In addition, many courts have addressed state-law claims that HMOs or other managed-care providers are liable for injuries resulting from policies, practices, or physician judgments related to cost containment. See generally William E. Milks, J.D., Annotation, *Liability of Health Maintenance Organizations (HMOs) for Negligence of Member Physicians*, 51 A.L.R. 5th 271 (1997) (collecting cases holding HMOs accountable under a variety of legal theories, including vicarious liability based on apparent authority, respondeat superior, direct corporate negligence, breach of contract and breach of

¹⁵ (...continued)
2d 597 (S.D. Tx. 1998)). See also generally, U.S. Dep't of Health & Human Servs., *State Regulatory Experience with Provider-Sponsored Organizations* (1997).

¹⁶ See *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), cert. denied, 119 S. Ct. 1033 (1999); *Corporate Health Insurance, Inc. v. Texas Dep't of Insurance*, 12 F. Supp. 2d 597, 620-21 (S.D. Tx. 1998); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 69 (D. Mass. 1997); *Physicians Health Plan, Inc. v. Citizens Insurance Co. of Am.*, 673 F. Supp. 903, 905 (W.D. Mich. 1987).

warranty). See, e.g., *Pacificare, Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) (claims challenging the quality of the benefit provided are not preempted); *Ouelette v. Christ Hosp.*, 942 F. Supp. 1160, 1165 (S.D. Ohio 1996) (holding that negligence claim against HMO arising out of policy furthering cost containment is not preempted); *Maltz v. Aetna Health Plans*, 152 F.3d 919 (2d Cir. 1998) (table) (holding that allegations about reduction in the quality of care are properly brought under state law); *Petrovich v. Share Health Plan, Inc.*, No. 85-726 (Ill. filed Sept. 30, 1999) (same); *Pappas v. Asbel*, 724 A.2d 889, 893 (Pa. 1998) (same), *petition for cert. filed*, 67 USLW 3717 (U.S. May 13, 1999) (No. 98-1836). See generally *McEvoy v. Group Health Coop.*, 570 N.W.2d 397 (Wis. 1997) (same); *Wilson v. Blue Cross*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990) (same).

There is no dearth of regulatory activity in this area and thus no vacuum that ERISA should expand to fill. To the contrary, the extant and prospective federal and state regulation of managed care indicates that the Congress did not intend ERISA to preclude either managed care or legislative regulation of managed care.

* * * *

In sum, numerous medical and business judgments made by an HMO or its physicians may have some indirect effect on benefits. But such judgments do not alter a plan or deprive any participant or beneficiary of plan benefits. They therefore are *not* exercises of discretion in the "management" or "administration" of an ERISA "plan" resulting in fiduciary liability, but rather "exercise[s] of managerial discretion in the administration of [an HMO's] business." App. 53a (Easterbrook, J., dissenting). Petitioners thus were not acting as fiduciaries when they implemented the cost-containment mechanism at issue here.

II. AN ALLEGATION THAT AN HMO FINANCIALLY REWARDS ITS OWNER PHYSICIANS FOR SUCCESSFUL COST-CONTAINMENT DOES NOT STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY.

In amended Count III of her complaint, Herdrich alleges that the same administrators:

vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who become eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. [App. 19a (emphasis omitted).]

The court of appeals held that these allegations state a claim for fiduciary breach. It observed that under petitioners' cost-containment mechanism, the individuals making fiduciary judgments (HMO administrators and physicians) have a financial incentive not to make appropriate decisions about plan benefits and thus operate under a conflict of interest. The existence of these financial incentives, the court stated, breaches petitioners' fiduciary duty to plan participants and beneficiaries.

The lower court's decision is based on a fundamental misunderstanding of the structure of ERISA. Its conclusion that petitioners' cost-containment mechanism is unlawful simply because it creates divided loyalties in administrators and

physicians who make fiduciary decisions is wrong. As stated *supra* at 34, ERISA specifically authorizes ERISA fiduciaries to have dual loyalties, *i.e.*, interests which conflict with those of plan participants and beneficiaries. See, *e.g.*, 29 U.S.C. § 1108(c)(3) (authorizing an employer to act as both plan sponsor and plan administrator). Indeed, ERISA defines an institution or individual as a fiduciary only "to the extent that" that institution or individual is making discretionary judgments under the plan, so that those with interests that conflict with the interests of plan participants (such as employers and employer representatives) may nonetheless administer ERISA plans. *Id.* § 1002(21)(A). This Court has often contrasted ERISA's authorization of dual loyalties with the "common law of trusts [which] prohibits fiduciaries from holding positions that create [a] conflict of interest with trust beneficiaries." See *Varity Corp. v. Howe*, 516 U.S. 489, 498 (1996) (citing *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-30 (1981)).

Congress thus has made clear, and this Court has confirmed, that a person who is an ERISA fiduciary may *have* conflicting loyalties. In fact, when making decisions that are not themselves fiduciary, an ERISA fiduciary may also *act* on those conflicting loyalties without breaching any fiduciary obligation under ERISA. See *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996).

Under ERISA, for example, an employer that is also a plan sponsor decides what health benefits to offer and makes plan design, modification, and amendment decisions unencumbered by fiduciary obligations under ERISA; in so doing, the employer may keep its eye firmly fixed on its bottom line and place whatever limits it chooses on the health care benefits provided by the plan. That same employer, when acting as plan administrator, must make decisions about the specific distribution of benefits under the plan as a fiduciary with an "eye

single" to the interests of the patient/beneficiaries. See, *e.g.*, *Hughes*, 119 S. Ct. at 763 ("an employer's decision to amend a pension plan concerns the composition or design of the plan itself and does not implicate the employer's fiduciary duties which consist of such actions as the administration of the plan's assets").

Hughes and *Lockheed* are illustrations of the general point that individuals who act as ERISA fiduciaries when making plan-benefit decisions do not breach their duty to plan participants simply because they simultaneously have a financial interest in denying benefits to plan participants. Indeed, these cases go further. They demonstrate that ERISA allows individuals who are ERISA fiduciaries not only to have interests which conflict with those of plan participants, but also to *act* on those conflicting interests when making decisions that are not fiduciary in nature.

Analogously here, an employer may decide to provide health benefits through an HMO. The HMO and its physician owners employ cost-containment mechanisms and make other business and medical determinations with an eye to containing the HMO's costs and increasing its income. Assuming that the plan benefits are the specific medical services provided by the HMO, but see Part I.A.1., *supra*, that same HMO and its physicians must make decisions about plan benefits with an "eye single" to the interests of the patient/beneficiaries. The existence of a conflicting financial interest (in increasing the HMO's income), by itself, does not state a claim for breach of fiduciary duty. Cf. App. 58a (Easterbrook, J., dissenting) ("Lawyers owe fiduciary duties to their clients. Can it be that the incentive given by the partnership's reward structure to substitute the services of associates for those of partners creates a conflict of interest that invariably violates those duties? If the answer is 'no' for law firms (and that must be the right answer), it is 'no' for HMOs, in stock or partnership form").

The decision below is thus inconsistent with the text of ERISA and with this Court's decisions. And, like the holding that an HMO is acting as a fiduciary when it makes decisions that indirectly affect benefits, it also nullifies Congress' decision to authorize and nurture HMOs. See *supra* at 4-5. The conflict of interest cited by the court of appeals is present virtually every time that an HMO or other managed-care organization makes a medical or business decision. As described *supra* at 27, every provider which bears the financial risk of providing health care has a substantial incentive to contain costs. By definition, then, there is a tension between such a provider's duty to patients and its financial interest. Thus, a determination that such a conflict breaches a fiduciary duty under ERISA is a determination that HMOs and other managed-care arrangements may not provide benefits under an ERISA plan. Reasonable people can and do differ about the relative efficacy and benefits of fee-for-service and managed-care arrangements for health-care delivery, but Congress' decision to authorize managed-care arrangements should not be overruled by an unduly broad interpretation of ERISA.¹⁷

Ironically, fee-for-service medicine also creates a conflict between the financial interest of the provider and the patient's interests, because in that setting, the health-care provider's financial interest is to prescribe the most

¹⁷ See, e.g., *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 753 (S.D.N.Y. 1997) ("Weiss' contention that CIGNA's compensation package [for physicians] facially violates ERISA simply because it deprives her of her right to receive 'medical opinions and referrals unsullied by mixed motives,' . . . is tantamount to a claim that risk-sharing arrangements in managed care are inherently illegal, a position that is refuted by federal and New York law. See 42 U.S.C. § 300(e)(2); 42 C.F.R. § 417.103(b); N.Y. Pub. Health Law § 4403(1)(c). Moreover, plaintiff's concern about the soundness of managed care policy is best suited for resolution by branches of government other than the judiciary."). See also *Maltz v. Aetna Health Plans*, 152 F.3d 919 (2d Cir. 1998) (table).

remunerative care possible. Too much medical care, like too little, could harm patients; excessive medical treatment also increases the cost of health care generally. The point is not that an allegation that an ERISA plan provides fee-for-service health care states a claim for breach of fiduciary duty. Instead, the point is that neither fee-for-service nor managed care places the physician in a situation free of conflict. If a provider breaches ERISA whenever he or she makes health-care decisions operating under a financial conflict of interest, both fee-for-service and managed care are unlawful.¹⁸

For reasons touched on *supra* at 29-30, it is particularly ironic that the court of appeals extended the scope of ERISA fiduciary liability in a case involving a *physician-owned* managed-care plan. Physician-controlled health plans have been advocated as an antidote to the perceived tension between the goals of providing quality patient care and containing costs, because physicians' decisions are already governed by professional ethical codes and obligations and by the law of medical malpractice. See Hirshfeld, *supra*. These constraints ameliorate the conflict of interest inherent in the HMO structure, because physicians are less likely than other HMO owners to make business and medical judgments solely on the basis of financial interest.

* * * *

¹⁸ It is possible that, under the court of appeals' decision, an ERISA fiduciary could attempt to prove that a particular form of managed care did not actually create a conflict of interest. But at the very least, the decision would "commit[] the court[s] to a long (and I should think unhappy) course of distinguishing 'good' managed-care systems from 'bad' ones." See App. 58a (Easterbrook, J., dissenting). Of course, the judiciary makes many judgments in specialized areas when the Constitution or the Congress requires it to do so, but the decision below would stretch ERISA out of its natural shape, ignore prior decisions of this Court, and partially nullify an act of Congress in order to appropriate these policy judgments for federal courts.

In sum, unlike the common law of trusts, ERISA contemplates that persons acting as ERISA fiduciaries may have divided loyalties. Accordingly, the bare allegation that petitioners have divided loyalties does not state a claim for breach of fiduciary duty under ERISA.

III. HERDRICH'S FAILURE TO ALLEGE DAMAGE TO THE PLAN DEMONSTRATES THAT SHE FAILED TO STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY.

Herdrich's failure to allege damage to an ERISA plan provides a further demonstration that she has not stated a claim for breach of fiduciary duty under ERISA. According to Herdrich, "the [p]lan" was injured by the year-end financial distribution from HAMP to its owners, the Carle Clinic physicians. Complaint ¶ 13 (App. 87a). This argument necessarily assumes that the plan included a trust fund for the benefit of plan members and that these financial distributions were part of the corpus of that trust. State Farm, however, establishes no such trust. See generally App. 93a-128a (Group Subscription Certificate). Cf. 42 U.S.C. §§ 1102, 1103 (setting out the detailed requirements for establishing an ERISA trust in a plan).

Indeed, it is difficult to conceive of what purpose a trust would serve in the context of a health-care benefit plan. We assume *arguendo*, as Herdrich alleges in her Complaint (App. 84a), that the benefit provided by the ERISA plan is "arrang[ing] for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate." App. 93a. Petitioners do not manage funds for participants and beneficiaries or administer any financial benefit which might necessitate the existence of a trust. Indeed, Herdrich does *not* claim that the financial distribution to the Carle physicians resulted in the denial of any benefit under

the plan -- *i.e.*, a failure to arrange medical or hospital services consistent with the terms of the Group Subscription Certificate. Thus, Herdrich's Complaint fails to allege any damage to the plan because the money paid to HAMP under its contract with State Farm is not part of any plan trust and the payment of some portion of that money to HAMP's owners does not deprive plan participants of any benefit promised under the plan.¹⁹

Even assuming (counter factually) that the plan included a trust for the benefit of subscribers, Herdrich's Complaint still fails to state a claim because her damages claim is fundamentally inconsistent with her theory of liability in two independent respects. *First*, Herdrich asserts (correctly) that the Carle physicians own HAMP. Complaint ¶ 2 (App. 84a). Thus, the Carle physicians are entitled to any proceeds properly earned by HAMP from delivering health-care benefits to plan participants. (As explained above, the money earned by HAMP from cost-containment mechanisms is the consideration HAMP receives from State Farm for arranging medical and hospital services for plan subscribers and cannot be considered part of a plan trust.) Accordingly, the financial distribution from HAMP to the Carle physicians does not deprive the plan of assets. It simply transfers HAMP's earnings to HAMP's actual owners.²⁰

¹⁹ The absence of damage to the plan is underlined by an examination of section 409 of ERISA, which expressly addresses liability, and hence damages, for fiduciary breach. When a plan fiduciary breaches his or her duty, he or she is "personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." 29 U.S.C. § 1109. This provision simply makes no sense here because there is no loss of any plan asset and no profit to any fiduciary based on the use of plan assets.

²⁰ Indeed, as the owners of HAMP, the Carle physicians can charge HAMP whatever fees they wish for their services. As a result, the physicians could
(continued...)

Second, Herdrich asserts that financial distributions paid to Carle physicians were obtained "[a]s a direct and proximate result of defendants' breach of their fiduciary duties." Complaint ¶ 13 (App. 87a). In other words, the money for the payments was earned by the conduct alleged to constitute a breach of fiduciary duty. Without the fiduciary breach, the plan would not have had this money to pay out to its physician owners as income. If that is so, it makes no sense to allege that payment of that money *damaged* the plan. With or without the alleged breach, the plan would not have had the money at issue.

Herdrich's failure to allege damage to an ERISA plan independently demonstrates that she has failed to state a claim for breach of fiduciary duty actionable under ERISA.

CONCLUSION

The decision of the court of appeals should be reversed.

²⁰ (...continued)

eliminate the end-of-the year distribution from HAMP merely by increasing the rates they charge HAMP. There is no independent economic significance to the financial distributions which HAMP's owners (the Carle physicians) make to the Carle Clinic Association (the Carle physicians). To the contrary, these distributions are simply accounting transactions.

Respectfully submitted,

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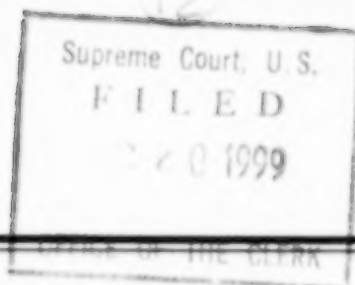
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November 19, 1999

DEC 20 1999

No. 98-1949



IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION
and HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR RESPONDENT

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QUESTION PRESENTED

Whether a non-sponsor fiduciary may design and administer an ERISA benefit plan so as to increase its profits to the detriment of the plan participants.

PARTIES TO THE PROCEEDING

Carle Clinic Association, P.C. is an Illinois professional corporation comprised of licensed physicians, dentists and podiatrists. Health Alliance Medical Plans, Inc. is a for-profit Illinois domestic stock insurance company and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (Resp. app. 42a). Carle Health Insurance Management Company is a for-profit Illinois corporation and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (Resp. app. 42a).

These three entities file a consolidated income tax return. (Resp. app. 44a). Pursuant to Article III, Section 2 of Health Alliance's corporate by-laws, an appointment to the Board of Governors of Carle Clinic Association, P.C. results in an automatic appointment to the Board of Directors of Health Alliance. (Resp. app. 45a).

Neither Dr. Pegram, nor any other individual physician, is a party defendant in Amended Count III. (Pet. app. 83a).

TABLE OF CONTENTS

	<i>Page</i>
Question Presented	i
Parties to the Proceeding	ii
Table of Contents	iii
Table of Cited Authorities	v
Statement of the Case	1
Summary of Argument	11
Argument	12
I. A Non-Sponsor Fiduciary May Not Design And Administer An ERISA Benefit Plan So As To Increase Its Profit To The Detriment Of Plan Participants.	17
A. Petitioners Function as ERISA Fiduciaries When Designing and Administering a Welfare Benefit Plan	17
B. Non-Sponsor Fiduciaries Cannot Operate in Dual Capacity	25
II. Structural Conflicts Are Actionable Under Section 406 "Per Se" Prohibitions, Whether Direct Or Indirect.	29

Contents

	<i>Page</i>
III. ERISA's Fiduciary Duties Are Based On The Common Law Duty Of Loyalty.	40
Conclusion	43

TABLE OF CITED AUTHORITIES

	<i>Page</i>
Cases:	
<i>Buck v. Quykendall</i> , 267 U.S. 307 (1925)	27
<i>Central States, S.E. & S.W. Areas Pension Fund v. Central Transport, Inc.</i> , 472 U.S. 559 (1985) ..	40, 41
<i>Cigna Property and Casualty Ins., Co. v. Polaroid Pictures Ass'n.</i> , 159 F.3d 412 (9th Cir., 1998) ..	27
<i>Cleveland v. Policy Management Systems Corporation, et al.</i> , 526 U.S. 795 (1999)	26
<i>Conley v. Gibson</i> , 355 U.S. 41 (1957)	30
<i>Continental Illinois Corp. v. C.I.R.</i> , 998 F.2d 513 (7th Cir., 1993)	27
<i>Cooke v. Lynn Sand & Stone Co.</i> , 673 F. Supp. 14 (D. Mass., 1986)	28
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	Page
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<i>Donovan v. Bierwirth</i> , 680 F.2d 263 (2nd Cir.), cert. denied, 459 U.S. 1069 (1982)	39, 40
<i>Donovan v. Daugherty</i> , 550 F. Supp. 390 (S.D. Ala., 1982)	38
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<i>FMC Corporation v. Holiday</i> , 498 U.S. 52 (1990)	3
<i>Gilliam v. Edwards</i> , 492 F. Supp. 1255 (D.C.N.J.)	38
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Cited Authorities

	Page
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<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	26
<i>Lowen v. Tower Asset Management, Inc.</i> , 653 F. Supp. 1542 (S.D.N.Y.), aff'd., 829 F.2d 1209 (2nd Cir., 1987)	22
<i>Lydon v. Boston Sand & Gravel</i> , 175 F.3d 6 (1st Cir., 1999)	28
<i>Marshall v. Kelly</i> , 465 F. Supp. 341, (W.D. Ok., 1978)	38
<i>Marshall v. Snyder</i> , 1 EBC 1878 (E.D.N.Y., 1979)	38
<i>Massachusetts Mutual Life Ins., Co. v. Russell</i> , 473 U.S. 134 (1985)	41
<i>McLain v. Real Estate Bd. of New Orleans, Inc.</i> , 44 U.S. 232 (1980)	30
<i>Mertens v. Hewitt Associates</i> , 508 U.S. 248 (1993)	18
<i>Moser v. United States</i> , 341 U.S. 41 (1951)	28

Cited Authorities

	Page
<i>NLRB v. Amax Coal Co.</i> , 453 U.S. 322 (1981)	41
<i>N.Y. Conference of Blue Cross & Blue Shield Plans v. Traveler's Ins.</i> , 514 U.S. 645 (1995)	18, 26
<i>Oneida Motor Freight, Inc. v. New Jersey Bank</i> , 848 F.2d 414 (3rd Cir., 1988)	28
<i>Pacificare v. Martin</i> , 34 F. 3d 834 (9th Cir., 1994)	20
<i>Pilot Life Ins. Co. v. Dedeaux</i> , 481 U.S. 41 (1987)	34
<i>Reilly v. Blue Cross & Blue Shield United of Wis.</i> , 846 F.2d 416 (7th Cir., 1988)	21
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<i>UNUM Life Ins. Co. v. Ward</i> , 119 S. Ct. 1380 (1999)	34
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	18, 25, 34, 40
<i>Waller v. Blue Cross of California</i> , 32 F.3d 1339 (9th Cir., 1994)	28

Cited Authorities

	Page
Statutes:	
Omnibus Budget Reconciliation Act of 1990, Section 4204(a)(1)	13
Social Security Act, § 1876(i)	13
ERISA § 3(14)	33
26 CFR § 1.162-7	37
29 CFR § 2509.75-8	22
29 CFR § 2550.408(c)(2)	36, 37
29 CFR § 2560.503-1	22
42 CFR § 417.479	14
28 U.S.C. § 1367	5
29 U.S.C. § 1001(b)	18
29 U.S.C. § 1002(1)	3, 18
29 U.S.C. § 1002(14)	33
29 U.S.C. §§ 1021-1031	18
29 U.S.C. §§ 1051-1061	18

Cited Authorities

	<i>Page</i>
29 U.S.C. §§ 1081-1086	18
29 U.S.C. § 1101	5
29 U.S.C. §§ 1101-1114	18
29 U.S.C. § 1104(a)	30
29 U.S.C. § 1104(a)(1)	31, 42
29 U.S.C. § 1104(a)(1)(A)	40
29 U.S.C. § 1106	29, 31, 33, 35, 36
29 U.S.C. § 1106(a)	32
29 U.S.C. § 1106(b)(1)	33
29 U.S.C. § 1107(a)	32
29 U.S.C. § 1108	31, 37
29 U.S.C. § 1108(c)	35
29 U.S.C. § 1108(c)(2)	36, 38
29 U.S.C. § 1108(c)(3)	25
29 U.S.C. § 1109(a)	41

Cited Authorities

	<i>Page</i>
42 U.S.C. § 300e	12
815 ILCS 505/1, <i>et seq.</i>	5
Rules:	
Fed. R. Civ. P. 8(a)(2)	30
Fed. R. Civ. P. 12(b)	7
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	<i>Page</i>
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STATEMENT OF THE CASE

In March of 1991, respondent's husband was employed by State Farm Mutual Automobile Insurance Company (hereinafter "State Farm"). (Pet. app. 84a). Through State Farm, Health Alliance Medical Plans, Inc. (hereinafter "HAMP") sold respondent a subscription in CarleCare HMO, a pre-paid health insurance plan. (hereinafter "the Plan") (Pet. app. 84a). The Joint Appendix includes the State Farm "Summary Plan Description" (hereinafter "SPD") for health benefits. State Farm provides its employees with two health insurance options: traditional group medical (section II of SPD) (Jt. app. 51) and an HMO (section III of the SPD). (Jt. app. 101).

State Farm designed and administers the group medical insurance program. (Pet. app. 85a). The SPD description of State Farm's group medical plan is both lengthy and detailed, running from page 51 of the Joint Appendix to page 101. The HMO benefits, on the other hand, are not designed and administered by State Farm. (Pet. app. 85a). Section III (Health Maintenance Organization) of the SPD is very abbreviated, only running from page 101 of the SPD to page 104. Concerning the HMO option, the State Farm SPD states:

Upon request, information will be provided to any employee interested in the HMOs listed. Information in the form of written materials concerning (a) the nature of services provided to members; (b) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participating in the HMO) and circumstances under which services may be denied; (c) the procedures to be followed in obtaining such services; and (d) the procedures available for the

review of claims for services which are denied in whole or in part.

Requests for any of the information listed in the above paragraph may be directed to the Plan Administrator and the Plan Administrator will forward all requests to the appropriate HMO carrier. A brief summary of each HMO's benefits, grievance procedures and procedures for submitting eligible expenses appears in the appendix.

Although State Farm Mutual Automobile Insurance Company is the Plan Administrator and Plan Sponsor for the Group Medical Plan (including HMO alternatives), any and all benefit determinations will be made by each individual HMO according to its operating procedures. (Jt. app. 101, 102)

* * *

HEALTH MAINTENANCE ORGANIZATION APPENDIX

THIS APPENDIX TO THE HMO SECTION IS NOT MEANT TO BE ALL INCLUSIVE OF "BENEFITS AND RESTRICTIONS PROVIDED BY THE HMO." FOR A SCHEDULE OF ALL BENEFITS AND RESTRICTIONS, PLEASE CONTACT THE PLAN ADMINISTRATOR AND REQUEST ADDITIONAL INFORMATION. THE HMO WILL BE ASKED TO SEND MORE DETAILED INFORMATION TO YOU.

On the following pages we have tried to describe the benefits available under the various HMO options. This information has been obtained directly from the HMO's contract or HMO's Representative. If the following information contains any statements that disagree with the HMO contract, then the HMO contract shall govern. (emphasis in original) (Jt. app. 103, 104).

The Plan¹ sets forth a service schedule in section 6 (Pet. app. 102a) which specifies the services which respondent is entitled to receive as a participant. Section 7 of the Plan (Pet. app. 111a) discloses the Plan limitations including the fact that "[d]iagnostic and treatment services by non-CarleCare Physicians are provided only when referred by the Primary Care Physician." (Pet. app. 111a). The Plan also states that participants are limited to care that is medically necessary.

The determination of what is or is not medically necessary is left to the judgment of the Carle physicians. Section 8.3 excludes "services or supplies which are not, in the judgment of CarleCare Physicians, Medically Necessary for the medical treatment or for the maintenance or improvement of the health of the Members." (Pet. app. 118a). Neither the State Farm SPD nor the Carle Subscription Certificate contain any disclosures

1. In her *amicus* brief, the Secretary of Labor (hereinafter "Secretary") argues that the State Farm SPD is "the Plan." This is a distinction without a difference. As stated above, the State Farm SPD defers to the HMO group subscription certificate. The definition of an ERISA "welfare plan" (29 U.S.C. § 1002(1)) includes "any plan, fund, or program maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.'" Indeed this court refers to the health certificate itself as "the Plan." See *FMC Corporation v. Holiday*, 498 U.S. 52 (1990).

that Carle physicians have a financial incentive not to treat plan members. Respondent was not advised that, in addition to the specified Plan limitations to which respondent agreed, respondent's treating physicians received bonuses or "supplemental" income derived from the minimization of diagnostic testing, minimization of referrals to specialists, and minimization of use of non-network facilities.

In March of 1991, respondent's primary care physician discovered a 6 x 8 centimeter "mass" (later determined to be her appendix) in respondent's abdomen. 154 F.3d 362, 374. Although the mass was inflamed on March 7, the primary care physician delayed instituting immediate treatment of respondent, and forced her to wait more than one week (eight days) to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass. Ideally, respondent should have had the ultrasound administered with all speed after the inflamed mass was discovered in her abdomen in order that her condition could be diagnosed and treated before deteriorating as it did, but Carle's policy requires plan participants to receive medical care from Carle-staff facilities. *Id.* Respondent was forced to wait the eight days before undergoing the ultrasound at a Carle facility in Urbana, Illinois. During this unnecessary waiting period, respondent's health problems were exacerbated and her appendix ruptured, resulting in the onset of peritonitis. In an effort to defray the increased costs associated with the surgery required to drain and cleanse respondent's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that respondent travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois. *Id.*

Respondent filed a two-count complaint in state court on October 21, 1992. (Pet app. 3a). Count I alleged medical

negligence against the primary care physician for failing to adequately examine, treat, and follow-up on respondent's complaint of right, lower quadrant pain. Respondent claimed that the primary care physician's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II sought to hold Carle Clinic Association liable under the theory of respondeat superior. Pegram and Carle Clinic filed an Answer to the state court complaint on December 8, 1992. (Resp. app. 6a).

Because it appeared that all the decisions as to respondent's treatment could be explained on the basis on a profit motive, respondent filed an addendum to her state court complaint in February 1994, adding Counts III and IV. Count III alleged that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plan in violation of the Illinois Consumer Fraud Act, 815 ILCS 505/1 *et seq.* Count IV charged Health Alliance breached its duty of good faith and fair dealing. (Resp. app. 6a).

The petitioners filed a Notice of Removal on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Respondent filed a Motion to Remand on April 8, 1994. (Resp. app. 6a).

In opposition to the Motion to Remand, petitioners argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, petitioners set forth a Synopsis of Relevant Facts which stated that respondent was a participant and beneficiary in an employee

benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. Petitioner's factual synopsis also asserted that Health Alliance was the administrator and fiduciary of the Plan. In their memorandum in opposition to respondent's motion to remand, petitioners stated:

The plaintiff, respondent, was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her by her husband's employer, State Farm Insurance Companies. ***Defendant, Health Alliance Medical Plans, Inc. ("Health Alliance") was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. Section 1001 et seq.)*** (Resp. app. 24a) (emphasis added)

* * *

In the case now before this Court, it is clear that the plaintiff's claims relate to the Plan administered by Health Alliance. The relationship between the plaintiff and Health Alliance arose solely from the Plan. ***But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and Health Alliance's serving as administrator/fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and Health Alliance and thus no lawsuit.*** (Resp. app. 36a) (emphasis added)

Petitioners filed a motion for summary judgment as to counts III and IV only. 154 F.3d 362, 366. The trial court granted summary judgment against respondent on count IV "to the extent (she) relies on § 502(a)(3)(b) (of ERISA) as a basis for monetary relief as opposed to equitable relief" and found that

that provision does not provide for extra-contractual damages. *Id.* While the trial judge denied the petitioner's summary judgment motion as to count III, he did conclude ERISA pre-empted that count, and granted respondent "leave to submit and amended count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." *Id.* On September 1, 1995, respondent filed her amended count III in accordance with the court's instructions. Thereafter, petitioners moved, pursuant to Rule 12(b) of the Federal Rules of Civil Procedure, to dismiss respondent's amended count III for failure to state a claim upon which relief could be granted. 154 F.3d 362, 367.

In dismissing respondent's amended count III, the trial court relied on petitioner's representations that they were ERISA fiduciaries, as reflected in the following findings of the trial court:

In opposition to the Motion to Remand, Defendants argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, Defendants set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. The factual synopsis also asserted that Defendant Health Alliance was the administrator and fiduciary of the Plan. Finally, Defendant contended that as part of the Plan, Health Alliance contracted with Carle Clinic to provide medical care to Plan participants in accordance with an agreed upon fee schedule. (Pet. app. 67a).

* * *

Defendants state, without reference to supporting material, that Carle HMO acts as the fiduciary of the Plan. However, the Defendants also frame the issues contained in the Motion for Summary Judgment as "whether an ERISA plan participant/beneficiary may sue an ERISA plan fiduciary under Illinois common law and under the Illinois Consumer Fraud Act, 815 ILCS 505/1, *et seq.*, to recover extra-contractual damages," indicating that Carle Clinic and Health Alliance function as fiduciaries. This statement, taken in conjunction with the prior representations made by Defendants, indicates that there are three fiduciaries of the Plan: Carle Clinic, Health Alliance, and Carle HMO. (Pet. app. 69a).

Respondent's malpractice counts went to trial in early December, 1996, and the jury returned a verdict in respondent's favor, awarding her \$35,000 in compensatory damages. Because respondent's ERISA count had been dismissed, the jury heard no evidence concerning the fact that respondent's physicians had a financial incentive to minimize respondent's treatment.

The Court of Appeals for the Seventh Circuit reversed the trial court's dismissal of respondent's amended Count III. 154 F.3d 362. Because respondent's allegations of medical malpractice (dealing with the quality of care respondent received) were resolved through trial, neither Dr. Pegram, nor any other individual physician, is a party to this appeal. Amended count III contains no allegations of medical malpractice, nor does it contain any allegation of negligent selection or supervision of physicians. There are no allegations

in amended count III implicating any individual clinical decisions, nor are there any allegations in amended count III implicating the health care that respondent received. Amended count III does not allege that the providing of medical services is a fiduciary function.

State Farm is not a party-defendant in amended count III. State Farm did not design and administer the incentive scheme alleged. (Pet. app. 85a). Rather, respondent specifically alleged that Carle Clinic, through its wholly-owned subsidiaries, designed and administered the incentive scheme. *Id.* In his dissent to the denial of petitioners motion for rehearing *en banc*, Justice Easterbrook acknowledges that petitioners, not State Farm, designed and administered this incentive scheme, referring to it as "Carle's setup." (Pet. app. 57a).

The only cost containment mechanism at issue in respondent's amended count III is the physician incentive to withhold treatment. Pre-paid health plans, especially HMOs, contain various cost-control mechanisms. See "Defining Full and Fair Disclosure in Managed Care Contracts," 60 The Citation, no. 6 (AMA, 1990). Respondent's amended count III does not attack capitation arrangements, nor discounted fee arrangements. It does not attack features that limit members to HMO physicians or to HMO facilities. Amended count III does not attack pre-certification, nor utilization review. Neither does it attack the primary care physician's role as "gatekeeper" of HMO services. The sole focus of attention of amended count III is the design and administration of an undisclosed physician incentive to withhold treatment.

In his dissent, Justice Flaum characterized the majority opinion as concluding that "the mere existence of this asserted conflict without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." 154 F.3d at 381. But the majority stated:

That is not the conclusion we reach. Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

The dissent admittedly does "not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty." In its view, such a claim might very well be viable when "there is a serious flaw in the manner in which the incentive arrangement is established . . ."

Having said this, we fail to see how it can conclude that Herdrich did not plead such a flaw in the structure of the incentive program at issue.

* * *

Thus, Herdrich alleges a "serious flaw" that springs from the authority of physician/owners of Carle to simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals. Under the terms of ERISA, Herdrich most certainly has raised the specter that the self-dealing physician/owners in this appeal were not acting "solely in the interest of the participants" of the Plan. 154 F.3d 362, 373.

The court of appeals concluded:

In summary, we hold that the language of the plaintiff's complaint is sufficient in alleging that the defendants' incentive system depleted plan resources so as to benefit physicians who, coincidentally, administered the Plan, possibly to the detriment of their patients. The ultimate determination of whether the defendants violated their fiduciary obligations to act solely in the interest of the Plan participants and beneficiaries, see U.S.C. § 1104(a)(1), must be left to the trial court. 154 F.3d 362, 380

SUMMARY OF ARGUMENT

1. Neither Dr. Pegram, nor any other individual physician, is a defendant in respondent's amended count III. Amended count III makes no allegation of medical malpractice — quality of care is therefore not at issue. Amended count III does not address cost containment mechanisms generally — it focuses solely on physician incentive schemes.
2. As non-sponsors, petitioners function as ERISA fiduciaries by:
 - a) designing or "contracting" a physician incentive scheme whereby welfare benefit premiums are placed in a risk pool to fund health benefits, but physicians receive bonuses or "supplemental" income² from that same risk pool to the extent they withhold treatment; and

2. payments over and above their salaries

b) administering disputed and non-routine health claims.

3. A non-sponsor fiduciary cannot serve in dual capacities, and the doctrine of judicial estoppel precludes petitioners from arguing that they are not fiduciaries in the first instance.
4. A subscription or membership certificate is not a welfare plan benefit. Rather, medical care is the benefit conferred and plan participants suffer directly when medical care is withheld.
5. Congress enacted a broadly-worded and functional definition of an ERISA fiduciary. Rather than exempting large categories of plan administrators (i.e., HMOs or other managed care organizations) from ERISA, courts should maintain oversight of benefit plans, and, drawing upon the common law of trusts, decide these issues in a conservative, case by case approach.

ARGUMENT

In 1973 Congress passed enabling legislation allowing the formation of "health maintenance organizations." 42 U.S.C. § 300e. This legislation allows HMOs to "make arrangements with physicians or other health professionals, healthcare institutions or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions." *Id.* This statute does not prescribe the mechanisms whereby the risk of health care is shifted. Nor does this enabling legislation recommend any type of risk shifting or cost containment mechanism. There is nothing in this statute that

can be construed as Congressional sanctioning of undisclosed physician incentives.

In 1985 and 1986, federal officials became aware of physician incentives in managed care.³ In July of 1986, the U.S. General Accounting Office reported that some hospital physician incentive plans could lead to inappropriate reductions in service.⁴ Certain commentators noted that the striking fact about incentive schemes is that they are generally not disclosed in subscription agreements or plan documents. *See Havighurst, Health Care Choices: Private Contracts as Instruments of Health Reform*, 122 (1995).

Congress recognized the need to address these incentive schemes: HMOs participating in the Medicare program are prohibited from issuing incentive payments to individual physicians as an inducement to reduce medical care. Section 4204(a)(1) of the Omnibus Budget Reconciliation Act of 1990 added paragraph (8) to § 1876(i) of the Social Security Act to specify that each medicare contract with an HMO must stipulate that the organization must meet the following requirements if it operates a physician incentive plan: (a) that it not operate a physician incentive plan that directly or indirectly makes specific payments to a physician or physician group as an inducement to limit or reduce medically necessary services to a specific individual enrolled with the organization; and (b) that it disclose its physician incentive plan arrangements in detail that is sufficient to allow the Department of Health and Human Services Health Care Financing Administration (HCFA) to

3. GAO/HRD-89-29, "Medicare: HMO Physician Incentive Plans."

4. GAO/HRD-86-103, "Medicare: Physician Incentive Payments by Hospitals Could Lead to Abuse."

determine whether the arrangements comply with departmental regulations. *See* 42 CFR § 417.479.

At approximately the same time, the American Medical Association was attempting to assess the impact of physician incentives.⁵ In 1990, the AMA published its report, "Financial Incentives to Limit Care: Financial Implications for HMOs and IPAs" and in June of 1994, the AMA's House of Delegates adopted the AMA's Council on Ethical and Judicial Affairs report, "Ethical Issues and Managed Care"⁶, stating that, while efforts to contain costs are critical, managed care can "reduce the quality of care received by patients. In particular, by creating conflicting loyalties for the physician, some of the techniques of managed care can undermine the physician's fundamental obligation to serve as patient advocate. Moreover, in their zeal to control utilization, managed care plans may withhold appropriate diagnostic procedures or treatment modalities for patients," and finding:

When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care should not place patient welfare at risk.

5. Some physicians argue that, while the new HCFA rules represent a sensible step, they are too limited in several senses: they apply only to managed care plans that contract with Medicare or Medicaid, and they require disclosure only if incentives exceed the 25% threshold, and only if enrollees explicitly request this information. *See* Mechanic & Schlesinger, "Impact of Managed Care on Patients' Trust", 275 JAMA no. 21 (June, 1996).

6. AMA Council on Ethical and Judicial Affairs, "Ethics and Managed Care," 273 JAMA no. 4 (Jan., 1995).

Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

Seeking to insulate its members from the obvious implications of hidden physician incentives, and based upon its 1990 report, in June of 1994 the AMA updated its Ethical Opinion 8.132 (Referral of Patients: Disclosure of Limitations) to read as follows:

Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.

Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care. Physicians may satisfy this obligation by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians should also promote an effective program of peer review to monitor and evaluate the quality of the patient care services within their practice setting.⁷

Recognizing the egregious nature of the conflict of interest created by physician incentive schemes, the AMA sought to

7. *Id.*

lessen the impact of the conflict by mandating disclosure of the incentive schemes. The AMA seeks to place the burden of disclosure on plan administrators — a burden that was not met by petitioners here.

In 1998, the New England Journal of Medicine published a survey of 766 California managed care physicians.⁸ Nearly 40% of those doctors reported that their HMO contracts included some form of bonus or other financial incentive designed to control costs. The median amount of the incentive actually received was \$10,500, but 13% reported more than \$40,000 “at risk.” More than half of all physicians reporting incentives said they felt pressure from the plans to limit referrals and 17% believed the pressure was “sufficiently severe to compromise the quality of care.” In an editorial accompanying that study, then-editor, Jerome P. Kassirer, suggested that HMO incentives to limit care represent an “intolerable threat to physicians’ integrity.”

Those same concerns are reflected in the findings of Concurrent Resolution 293 now before the U.S. House Subcommittee on Health & The Environment:

Whereas payment arrangements in which health plans or individual health care providers reap a financial benefit from providing less care threaten to compromise the quality of care;

* * *

Whereas managed care’s promise to slow health care inflation is questionable at best;

8. Grumbach, “Primary Care Physicians’ Experience of Financial Incentives in Managed Care Systems.” 339 N.E. J. Med. 1516 (1998).

* * *

Whereas while the States have done an excellent job regulating health plans within their jurisdiction, over 120,000,000 Americans are enrolled in ERISA plans that are beyond the reach of State regulation;

No one can seriously contend that physician incentives benefit plan members. No one can seriously contend that physicians incentives don’t create egregious conflicts of interest. The only question is whether ERISA can be used to address that conflict. For the reasons stated herein, respondent respectfully suggests the answer is yes.

I. A NON-SPONSOR FIDUCIARY MAY NOT DESIGN AND ADMINISTER AN ERISA BENEFIT PLAN SO AS TO INCREASE ITS PROFIT TO THE DETRIMENT OF PLAN PARTICIPANTS.

A. Petitioners Function as ERISA Fiduciaries When Designing and Administering a Welfare Benefit Plan

As stated by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (February 25, 1974) reprinted, 2 Legislative History of the Employee Retirement Income Security Act of 1974 at 3293:

The Committee has adopted the view that the definition of fiduciary is of necessity broad . . . A fiduciary need not be a person with direct access to the assets of the Plan . . . Conduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . .

In *Mertens v. Hewitt Associates*, 508 U.S. 248, 262 (1993), this court stated: "ERISA . . . defines "fiduciary" not in terms of formal trusteeship, but in functional terms of control and authority over the Plan. . . thus **expanding** the universe of persons subject to fiduciary duties." (emphasis added) ERISA's comprehensive regulation of employee welfare plans extends to those that provide "medical, surgical, or hospital care or benefits" for plan participants and their beneficiaries. 29 U.S.C. § 1002(1); *N.Y. Conference of Blue Cross v. Traveler's Ins.*, 514 U.S. 645, 649 (1995). ERISA does not go about protecting plan participants and their beneficiaries by requiring employees to provide any given set of minimum benefits, but instead **controls the administration** of benefit plans, see 29 U.S.C. § 1001(b), as by imposing reporting and disclosure mandates, §§ 101-111, 29 U.S.C. §§ 1021-1031, participation and vesting requirements, §§ 201-211, 29 U.S.C. §§ 1051-1061, funding standards, §§ 301-308, 29 U.S.C. §§ 1081-1086, and fiduciary responsibilities for plan administrators, §§ 401-414, 29 U.S.C. §§ 1101-1114. It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme. *Id.* (emphasis added). To "administer" a Plan is to "manage or supervise the execution . . . or conduct of" the Plan. Webster's *Ninth New Collegiate Dictionary* 57 (1991). *Dissent, Varity Corp. v. Howe*, 516 U.S. 489, 529, 530 (1996).

In its SPD, State Farm defers the administration of HMO benefits to the individual HMOs stating, "any and all benefit determinations will be made by each individual HMO according to its operating procedures." (Jt. app. 101, 102). In Section 8.3 of their Subscription Certificate, petitioners give themselves the discretion to determine what is and what is not medically necessary, excluding "services or supplies with are not, in the judgment of CarleCare Physicians, Medically Necessary for the medical treatment or for the maintenance of improvement

of the health of the Members." (Pet. app. 118a). In her complaint, respondent alleged that petitioners breached their ERISA fiduciary duties by funding their incentive scheme through two mechanisms: (1) designing the incentive scheme through its contracts, and then (2) administering the plan by determining what was or was not medically necessary. Paragraph 12(b) of the amended count III alleges:

b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

i. by **contracting**⁹ with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

- (1) minimize the use of diagnostic tests;
- (2) minimize the use of facilities not owned by CARLE; and
- (3) minimize the use of emergency and non-emergency consultation

9. Respondent does not allege, as contended by the Secretary, that petitioners seek to fund their incentive scheme by **providing** medical services. Rather, respondent alleges that petitioners seek to fund their incentive, in part, by **contracting** — that is to say, by negotiating, drafting and executing contracts — to employ undisclosed physician incentives.

and/or referrals to non-contracted physicians.

ii. **by administering disputed and non-routine health insurance claims**¹⁰ and determining:

- (1) which claims are covered under the Plan and to what extent;
- (2) what the applicable standard of care is;
- (3) whether a course of treatment is experimental;
- (4) whether a course of treatment is reasonable and customary; and
- (5) whether a medical condition is an emergency (Pet. app. 86a) (emphasis added)

The exercise of discretion in processing claims is the epitome of a fiduciary function.¹¹ See Cantor, "Fiduciary

10. Respondent made no allegations concerning ministerial duties attendant upon Plan administration. Rather, respondent addressed her allegations to discretionary duties — the administering of disputed and non-routine claims.

11. *Florence Nightingale Nursing Serv. v. Blue Cross/Blue Shield of Ala.*, 41 F.3d 1476 (11th Cir., 1995) ("Blue Cross was and is the claims administrator for the Plan and, in that capacity, had the fiduciary responsibility for receiving, processing, and paying claims"); *Pacificare v. Martin*, 34 F.3d 834, 837 (9th Cir., 1994) ("[i]nsurers can be ERISA
(Cont'd)

Liability in Emerging Health Care," DePaul Bus. L.J., 189, 190 (1997). A decision that a particular benefit is not covered by the plan involves plan administration, even though there is a medical component to the decision. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).

On pages 20 through 24 of her brief, the Secretary argues that the administration of a health benefit plan is a fiduciary function. Respondent concurs. The Secretary also argues that petitioners have acknowledged their fiduciary status and duty of loyalty by arguing on page 28 of their brief that an HMO, "must make coverage and eligibility decisions under the plan with an 'eye single' to the interest of the patient/beneficiaries." (Sec. Br. 26)¹² Again, respondent concurs. Furthermore, the Secretary has propounded regulations addressing claims

(Cont'd)
fiduciaries if, 'they are given the discretion to manage plan assets or to determine claims made against the Plan [; a]n insurer will be found to be an ERISA fiduciary if it has the authority to grant, deny or review denied claims'"); *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 85 (4th Cir., 1993) ("Blue Cross both insures and administers the payment of health care benefits . . . [; i]n its role as plan administrator, Blue Cross clearly exercises discretionary authority or discretionary control with respect to the management of the Plan and therefore qualifies as a fiduciary under ERISA"); *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416, 419 (7th Cir., 1988) ("[a]s the administrator of the employee benefit plan, Blue Cross is a fiduciary for ERISA purposes.")

12. The Secretary is also correct to point out that, on page 7 of their reply brief at the writ stage, petitioners "freely acknowledge that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, e.g., when they provide information to participants as required under ERISA **and when they make decisions about who is eligible for plan benefits.**" (emphasis added).

administration.¹³ 29 CFR 2509.75-8 states that the determining of benefit eligibility is a fiduciary function if discretion is exercised, i.e., if it involves more than ministerial functions. 29 CFR 2560.503-1 imposes ERISA fiduciary duties on those who implement the plan's claims procedure. Petitioners' argument that they were not acting as ERISA fiduciaries when designing and administering this Plan begs the question: When non-sponsors design, implement and administer an ERISA health plan, in what capacity are they serving?¹⁴

When an HMO contracts with an employer to provide medical benefits to its employees, the HMO does not set a premium that is calculated at merely a "break even" level. Rather, the premium charged to the employer by the HMO already has an "underwriting profit" or "after-tax return" built into it. Accident and health insurance is a property and casualty line of insurance, as opposed to being governed by the principles of life insurance ratemaking. The 1988 "Statement of Principles Regarding Property and Casualty Insurance Ratemaking" of the Casualty Actuarial Society states:

The purpose of this Statement is to identify and describe principles applicable to the determination

13. Department of Labor Regulations have been given substantial weight by courts interpreting the provisions of ERISA. See *Lowen v. Tower Asset Management, Inc.*, 653 F. Supp. 1542, 1555 n.10 (S.D.N.Y.), *aff'd*, 829 F.2d 1209 (2nd Cir., 1987).

14. Petitioners do not really attempt to answer this question. Instead, they seek to argue that State Farm designed and implemented the incentive plan. This argument assumes facts that directly contradict the Plan documents and the allegations of the complaint, which clearly state that petitioners designed, implemented and administered the incentive scheme.

and review of property and casualty insurance rates. The principles in this Statement are limited to that portion of the rate making process involving the estimation of costs associated with the transfer of risk.

In its section on definitions, the Statement indicates that "ratemaking is the process of establishing rates used in insurance and other risk transfer mechanisms," and that the Statement "is limited to principles applicable to the estimation of these costs," which "costs" include profit: "The underwriting profit and contingency provisions are the amount that, when considered with the net investment and other income, provide an appropriate total after-tax return." In his *Essentials of Managed Health Care*, 2nd ed., (ch. 23, Rating & Underwriting) (Aspen, 1997), author Kongstvedt describes how HMOs are obligated to use "community-based rating" and how the medical care of a member is expressed in terms of "per member — per month." Kongstvedt advocates the use of a "premium loading factor." After demonstrating how the cost of providing medical services, "per member — per month," might result in a figure of \$120, the author then uses a premium loading factor of 1.19 which means that, although the actuarial projection of medical costs "per member — per month" is only \$120, the monthly premium charged to the employer is \$142.80.

Moreover, the monthly premium charged to the employer is not the capitation payment forwarded to doctor actually providing the healthcare. From the capitation payments, HMOs make allocations to various funds, or risk pools, to pay for (1) primary care services, (2) specialty physician or referral services, and (3) institutional services, such as in-patient hospital and

skilled nursing facility services.¹⁵ Physician incentive payments generally come from these risk pools. *Id.* The Secretary's argument in note 4 on page 11 of her brief that petitioners had control over no assets because there was "apparently no underlying trust" is incorrect. Petitioners had complete control of the risk pools. The risk pools are assets of the Plan. Petitioners' management of those risk pools is a fiduciary function under ERISA.

It is important to note that neither Dr. Pegram, nor any other individual physician, is a party-defendant in amended count III. None of the facts set forth in amended count III alleged deviation from the required standard of medical care, or even negligent selection of physicians. In fact, there are no negligence allegations contained in amended count III. Moreover, the allegations of amended Count III do not address the quality of the healthcare that respondent received. The Secretary misreads respondent's complaint when arguing that petitioners were not acting as fiduciaries under the "treatment allegations." (Secretary's brief at 16) There are no "treatment allegations." The Secretary fails to give effect to the first clause in respondent's paragraph 12(b)(i) of the complaint which alleges, "**by contracting** with CARLE owner/physicians" (Pet. app. 86a) (emphasis added) petitioners created and managed risk pools from which they paid themselves bonuses funded by the withholding of medical treatment.¹⁶

15. GAO\HDR-89-29 "Medicare: HMO Physician Incentive Plans" p. 14

16. The allegations of respondent's amended count III do not seek to raise mere allegations of medical malpractice to the level of breach of ERISA fiduciary duties. Respondent concurs with the Secretary, and the *amicus* brief of the American Medical Association, that the providing of medical services by an HMO physician is not a fiduciary
(Cont'd)

B. Non-Sponsor Fiduciaries Cannot Operate in Dual Capacity

From the Plan documents and respondent's allegations, it is clear that petitioners, and not State Farm, designed and administered the plan benefits at issue here. Petitioners attempt to avoid liability by arguing that they serve in a "dual capacity" and that *to the extent* that they are only making entrepreneurial decisions, they are not serving in a fiduciary capacity. This argument does not withstand scrutiny. Firstly, although ERISA does contemplate dual capacities (29 U.S.C. § 1108(c)(3)), respondent is unaware of any cases in which dual capacity has been conferred upon any party other than a plan sponsor (i.e., employer, union representative, etc.)¹⁷ In *Varity*, the dissent explained the basis of the "to the extent" clause when it stated:

This "artificial definition of fiduciary," *Mertens*, *supra* at 255, n.5, is designed, in part, so that an employer that administers its own plan is not a

(Cont'd)

function and that traditional medical malpractice actions should be left to state regulation.

It is also important to note that petitioners' decision to force respondent to wait an additional eight days for a sonogram after discovering respondent's abdominal mass is an administrative, not a medical decision. That is to say, there was no medical necessity that respondent wait eight days or that respondent use petitioners' sonography equipment.

17. See Annot., "Dual Loyalty Considerations in Determining Propriety Under Employee Retirement Income Security Act (29 U.S.C. §§ 1001 *et. seq.*), of Actions of Officers of Sponsor Corporations Serving as Trustees of Employment Pension Plans," 64 ALR Fed. 602 (Lawyer's Co-op., 1983).

fiduciary to the plan for all purposes and at all times, but only to the extent that it has discretionary authority to administer the plan. When the employer is not acting as plan administrator, it is not a fiduciary under the Act, and the fiduciary duty of care codified in Section(s) 404 is not activated. *Varity* at 528.

Courts and commentators have long recognized that, because ERISA does not mandate that plans be established and that certain benefits be offered,¹⁸ plan sponsors occupy a distinctive role.¹⁹ Protection afforded by the “to the extent” clause or by “dual capacity” status, inures to the benefit of a plan sponsor — but only to a plan sponsor.²⁰ Moreover, petitioners are precluded from arguing that they are not fiduciaries. The petitioners’ briefs before this Court contradict the representations they made in order to have the case removed and preempted. Now, petitioners argue that if the Court finds they are fiduciaries, it would unduly broaden preemption under ERISA! (Pet. Br. p. 37) Judicial estoppel and equitable estoppel prevent parties from manipulating the courts in this manner.

The doctrines of judicial and equitable estoppel, although clearly recognized by this Court,²¹ have largely been developed

18. *N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins.*, 514 U.S. 645 (1995).

19. Fischel and Langbein, “ERISA’s Fundamental Contradiction: The Exclusive Benefit Rule,” 55 Univ. Chi. L. Rev. 1105 (1988).

20. As they did in their petition for writ of certiorari, petitioners again cite *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755 (1999) and *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996). But those cases are inapposite as, unlike the case at bar, each dealt solely with the actions of a plan sponsor.

21. See *Cleveland v. Policy Management Systems Corporation, et al.*, 526 U.S. 795 (1999) (holding that plaintiff’s ADA claims will
(Cont’d)

by the courts of appeal. Although the courts of appeal have adopted slight variations in their interpretations of judicial estoppel, it is clearly intended to prevent parties from manipulating the courts by “gain[ing] an advantage by taking one position, and then seeking a second advantage by taking an incompatible position.” *Cigna Property and Casualty Ins., Co. v. Polaroid Pictures Ass’n.*, 159 F.3d 412, 419 (9th Cir., 1998). The Seventh Circuit noted that judicial estoppel is “to protect the courts from being manipulated by chameleonic litigants who seek to prevail, twice, on opposite theories.” *Levinson v. United States*, 969 F.2d 260, 264 (7th Cir., 1992).

A party can argue inconsistent positions in the alternative, but once it has sold one to the court it cannot turn around and repudiate it in order to have a second victory, which is what the IRS is seeking here. Having persuaded us to reject Continental’s efforts to show that the taxes were paid, the IRS may not argue against a restatement of income on the ground that they were really paid. Either they were or they weren’t.

Continental Illinois Corp. v. C.I.R., 998 F.2d 513, 519 (7th Cir., 1993). “Equitable estoppel serves to protect *litigants* from unscrupulous opponents who induce a litigant’s reliance on a position, then reverse themselves to argue that they win under an opposite scenario.” *Teledyne Industries, Inc. v. N.L.R.B.*, 911

(Cont’d)
not be automatically estopped because of a prior filing from SSDI benefits); *Huffman, et al. v. Pursue, Ltd.*, 420 U.S. 592 (1975) (merely noting that the court does not intend for its opinion to affect the overall rules of judicial estoppel in footnote 18); *Buck v. Quykendall*, 267 U.S. 307 (1925) (“a person who has invoked the benefit of an unconstitutional law cannot in a subsequent litigation aver its unconstitutionality as a defense.”) (citations omitted).

F.2d 1214, 1220 (6th Cir., 1990), citing to *Moser v. United States*, 341 U.S. 41 (1951). (Emphasis added).

Equitable estoppel should apply here but, in the alternative, should this Court find that equitable estoppel does not apply, judicial estoppel should apply. Judicial estoppel examines the connection between the litigant and the judicial system, while equitable estoppel focuses on the relationship of the parties to the prior litigation. *Oneida Motor Freight, Inc. v. New Jersey Bank*, 848 F.2d 414, 419 (3rd Cir., 1988); *c.f. Lydon v. Boston Sand & Gravel*, 175 F.3d 6 (1st Cir., 1999) (judicial estoppel's dual goals are "to maintain the integrity of the judicial system *and* to protect parties from opponent's unfair strategies.")

Even ignoring the fact that, as non-sponsor fiduciaries, petitioners cannot claim they were acting in a "dual capacity," and even ignoring the fact that petitioners should be judicially estopped from now claiming they were not fiduciaries, petitioners' assertion that they were merely making a "business" or "entrepreneurial" decision fails. Respondent acknowledges that, as the plan sponsor, State Farm's business or entrepreneurial decision to offer group medical and an HMO is a decision beyond the purview of ERISA. But the implementation of this particular HMO is a different matter. Petitioners, not State Farm, implemented the particulars of this HMO. Courts have routinely held that implementation decisions are fiduciary decisions. *See Waller v. Blue Cross of California*, 32 F.3d 1339 (9th Cir., 1994); *District 65, United Auto Workers v. Harper & Row Publishers, Inc.*, 670 F. Supp. 550 (S.D.N.Y., 1987); *Cooke v. Lynn Sand & Stone Co.*, 673 F. Supp. 14 (D. Mass., 1986).

In other cases, the Secretary has argued that, if implementing an incentive scheme was considered to be an act

of plan administration, it would lead to an absurd result. *See Secretary's amicus brief in Lancaster v. Kaiser Foundation Health Plan of the Mid-Atlantic States*, 958 F. Supp. 1137 (E.D. Va., 1997). The Secretary explained that an HMO (Kaiser) has a financial incentive to arrange for medical care at the least expense to itself and that its decisions are business decisions because Kaiser could not effectively conduct itself as a business due to an inherent conflict of interest — its interest in keeping financially sound would conflict with its duty as a fiduciary to act solely in the interest of the participants. This raises an absolutely critical point in this case. Here HAMP, the entity hiring the doctors, is, in fact, the doctors. One is the alter ego of the other. Here there is no "absurd result" and there is no inherent conflict.

In their implementation of State Farm's decision to offer an HMO, petitioners created and administered a risk pool for health benefits from which petitioners paid themselves bonuses to the extent they withheld treatment.

II. STRUCTURAL CONFLICTS ARE ACTIONABLE UNDER SECTION 406 "PER SE" PROHIBITIONS, WHETHER DIRECT OR INDIRECT.

The Secretary acknowledges that an incentive scheme constituting a breach of fiduciary duty would be established

if the scheme provided incentives of such a nature that the individual deciding claims for benefits would be unable to set aside personal interests and make the benefits determination based on the terms of the Plan . . . For example, a compensation scheme that provided direct financial incentives to plan fiduciaries for making adverse rulings on benefits claims . . .

(Sec. Br. 28, 29) But the Secretary concludes that nothing in respondent's amended count III "suggests that respondent was intending to plead that petitioners employed the kind of unusual incentive scheme described above, in which those who decided disputed claims would be paid on the basis of how many claims they deny or would otherwise be paid in a way that violates ERISA's fiduciary duty." (Sec. Br. 29). The Secretary's analysis places far too great a pleading burden on respondent, and also fails to acknowledge that the "per se" prohibitions of § 406 prohibit any self-dealing, whether it is achieved directly or indirectly.

Respondent's amended count III was dismissed pursuant to Fed. R. Civ. P. Rule 12(b)(6). (Pet. Br. 10). To withstand a Rule 12(b) motion, respondent's allegations need only state a possible claim, not a winning claim. *See Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). A complaint may be dismissed for failure to state a claim only if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations. *Hishon v. King & Spaulding*, 467 U.S. 69 (1984). A complaint should not be dismissed unless it appears beyond doubt that that plaintiff can prove no set of facts in support of her claim which would entitle her to relief. *McLain v. Real Estate Bd. of New Orleans, Inc.*, 44 U.S. 232 (1980). For purposes of withstanding a Rule 12(b) motion to dismiss, "notice pleading" is sufficient. *Sinclair v. Kleindienst*, 711 F.2d 291 (D.C. Cir., 1983). The federal rules do not require a plaintiff to allege sufficient facts to establish her right to judgment. All that is required is a "short and plain" statement of what her claim is. Fed. R. Civ. P. 8(a)(2).

In paragraph 11 of her complaint, respondent quoted the "duty of loyalty" language of ERISA § 404(a) (29 U.S.C. § 1104(a)). A fiduciary's "duty of loyalty" under ERISA cannot

be understood without comparing the prohibited transaction scheme of ERISA with the duty of loyalty under the common law of trusts. Based on such a comparison, a compelling argument can be made that the drafters of ERISA consciously intended §406 to prohibit "structural conflicts" that were not always addressed by the common law. Klevan, "The Fiduciary's Duty of Loyalty Under ERISA Section 406(b)(1)," 23 Real Property, Probate and Trust Journal, 561 (1988)²² The heart of a fiduciary's duty of loyalty is contained in ERISA § 404(a)(1) and is repeated and reinforced in the prohibited transactions provisions of § 406 which provides:

(a) Transactions between plan and party in interest. Except as provided in section 408 [29 U.S.C. § 1108]:

- (1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect —
 - (A) sale or exchange, or leasing, of any property between the plan and a party in interest;
 - (B) lending of money or other extension of credit between the plan and a party in interest;
 - (C) furnishing of goods, services, or facilities between the plan and a party in interest;

22. Mr. Klevan authored this article at the time that he was senior director of Policy and Legislative Analysis, Pension and Welfare Benefits Administration, U.S. Department of Labor.

- (D) transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan; or
- (E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 407(a) [29U.S.C. §1107(a)]

(b) Transactions between plan and fiduciary.

A fiduciary with respect to a plan shall not —

- (1) deal with the assets of the plan in his own interest or for his own account,
- (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or
- (3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

The prohibitions contained in § 406(a) are against “direct or indirect” transactions and are not simply the embodiment of the common law prohibition against the trustee engaging in self-dealing. They are also the extension, in absolute form, of the common law rule that transactions between a trust and a

third party may be set aside if it can be shown that the trustee was improperly influenced by its relationship to the third party, or even its friendship with the third party, so that the trustee engaged in a transaction that was less advantageous to the trust than if the trustee were dealing at arm’s length. Klevan at 563. Section 406 provides a per se prohibition of these transactions with a category of persons known as ERISA § 3(14) “Parties in Interest,” which includes both fiduciaries and service providers to the Plan.²³ Instead of requiring proof that a fiduciary’s relationship with a third party might influence the best judgment of the fiduciary, it substituted an absolute rule that defines by statute those persons who are deemed to have such an influence. Thus, Congress dispensed with the need to show that the fiduciary was actually influenced to the detriment of the Plan. Klevan at 564.

Klevan also states that the Department of Labor’s position is that a § 406(b)(1) prohibition (barring self-dealing with plan assets) is a per se prohibition requiring a plan fiduciary who has a conflict of interest to step aside. Courts have had little difficulty in finding § 406(b)(1) violations in transactions between a plan and a fiduciary, given a direct conflict of interest in which the fiduciary’s gain is the plan’s loss. Klevan at 570.

Additionally, respondent takes issue with the Secretary’s characterization of the conflict created by petitioner’s incentive scheme as being “indirect.” Respondent alleged that HAMP created a structural conflict of interest by “contracting” to withhold treatment so that the savings realized can, in turn, be paid to HAMP’s owners — those same Carle physicians. This is hardly an “indirect” conflict of interest. In fact, it is difficult

23. 29 U.S.C. § 1002(14) states: [t]he term “party in interest” means, as to any employee benefit plan — (A) any fiduciary . . . (B) a person providing services to such plan.

to envision a more direct conflict. Every dollar saved by not ordering sonograms, by not referring patients to surgeons, or by refusing to send patients to the emergency room, goes directly into the pockets of petitioners. Respondent's allegations clearly make a claim for a direct conflict of interest.

Like Justice Easterbrook in his dissent to the denial of petitioner's motion for rehearing (Pet. app. 48a), petitioners argue that the plan participants here suffered no loss. Petitioners and Justice Easterbrook argue that the benefit conferred is mere membership in the Plan, not the benefits to be provided thereunder. Of course, employing this analysis, the employees of Massey Combines²⁴ would have had no cause of action because they still had membership in the Massey Combines nonpension benefits plan, it being irrelevant that the sponsor of that plan was bankrupt. But this court has rightly decided that the specific benefits conferred, not the naked subscription certificate, is the benefit offered (or, in this case, the benefit lost). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999). The Secretary is correct to disagree with the analysis of Justice Easterbrook. Here the very money that should have paid for respondent's emergency room visit, that should have paid for respondent's timely sonogram in her hometown, and that should have paid for respondent's surgery at the nearest hospital, instead went into petitioners' pockets. Respondent suffered a direct loss of benefits, as has each and every member of CarleCare HMO.

In her approach, the Secretary acknowledges that petitioners are fiduciaries, but argues that, as a matter of law, respondent has failed to allege any violation under ERISA because ERISA contemplates dual loyalties (Sec. Br. 28) and because the incentive scheme here is nothing more than a mechanism to

24. See *Varity v. Howe*, 516 U.S. 489 (1996).

compensate the petitioners who, as fiduciaries, are entitled, pursuant to 29 U.S.C. § 1108(c), to compensation for performance of their duties. (Sec. Br. 9).

But the Secretary's analysis is incomplete. Section 1108(c) has three subsections:

(c) Fiduciary benefits and compensation not prohibited by 29 U.S.C. § 1106. Nothing in section 406 [29 U.S.C. § 1106] shall be construed to prohibit any fiduciary from —

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full-time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

Subsections 1 and 3 are inapplicable on their face. The Secretary must be suggesting that nothing in §406 prohibits a fiduciary from receiving "reasonable compensation for services rendered" pursuant to § 1108(c)(2). The Department of Labor's regulation on this section (29 CFR § 2550.408(c)(2)) provides in pertinent part:

(2) *Payments to certain fiduciaries.* Under sections 408(b)(2) and 408(c)(2) of the Act, the term "reasonable compensation" does not include any compensation to a fiduciary who is already receiving full-time pay from an employer or association of employers (any of whose employees are participants in the plan) or from an employee organization (any of whose members are participants in the plan), except for the reimbursement of direct expenses properly and actually incurred and not otherwise reimbursed. The restriction of this paragraph (b)(2) do not apply to a party in interest who is not a fiduciary.

Petitioners are excluded from protection under 408(c)(2) because they are already paid a salary as full-time employees of Carle Clinic and/or HAMP.²⁵ Even if those physicians were not salaried, but instead retained the "per member — per month" capitation payment, they would still be disqualified from protection under section 1108(c)(2). 29 CFR § 2550.408(c)(2) further states:

(5) *Excessive compensation.* Under sections 408(b)(2) and 408(c)(2) of the Act, any compensation which would be considered excessive

25. In her complaint, respondent alleged that the incentive scheme payments were "supplemental." (Pet. app. 86a).

under 26 CFR 1.162-7 (Income Tax Regulations relating to compensation for personal services which constitutes an ordinary and necessary trade or business expense) will not be "reasonable compensation." Depending upon the facts and circumstances of the particular situation, compensation which is not excessive under 26 CFR 1.162-7 may, nevertheless, not be "reasonable compensation" within the meaning of sections 408(b)(2) and 408(c)(2) of the Act.

While 26 CFR 1.162-7²⁶ addresses the deductibility of ordinary and necessary business expenses, it nonetheless establishes that the applicable test is whether compensation is "reasonable" and whether it is "in fact payments purely for services." The Department of Labor has adopted the framework that the Internal Revenue Service regulations employ to determine if there is an excessive payment in contravention of 29 U.S.C. § 1108.²⁷

26. 26 CFR 1.162-7 states: "§ 1.162-7. **Compensation for personal services**

(a) There may be included among the ordinary and necessary expenses paid or incurred in carrying on any trade or business a reasonable allowance for salaries or other compensation for personal services actually rendered. The test of deductibility in the case of compensation payments is whether they are reasonable and are in fact payments purely for services.

27. It is important to note that the Department of Labor clearly intended a *broader* definition of excessive compensation to be used in the ERISA context than the definition used in the Internal Revenue Service. Regulation 2550.408(c)-2 makes the violation of 26 CFR 1.162-7 sufficient but not necessary for a determination that compensation is not "reasonable."

I.R.S. regulations prohibit certain types of excessive compensation in order to protect the tax base. Specifically, the IRS is concerned with corporations attempting to avoid taxation by calling what is really a dividend a "salary" and thereby claiming a deduction. *Dexsil Corporation v. Commissioner of Internal Revenue*, 147 F.3d 96 (2nd Cir., 1998).

The purpose of preventing excessive compensation in an ERISA context is to protect Plan benefits. State Farm and the Plan participants paid premiums to HAMP. That money was held by HAMP in a risk pool to provide for the medical care of the participants. Payments received by petitioners from the risk pool are not "in fact payments purely for services." Indeed, they are payments for *not* providing services.

The Secretary's argument with respect to petitioners being entitled to "reasonable compensation" has not been accepted by the courts. In *Gilliam v. Edwards*, 492 F. Supp. 1255 (D.C.N.J.), a union business manager agreed to act as an administrator of the union pension fund pursuant to a contract whereby he would be paid for his services as administrator. But when challenged by union participants, the court held that the business manager was not exempt under § 408(c)(2) because his salary as business manager was substantial enough to qualify as full-time pay, and therefore any additional compensation he received as administrator was not "reasonable compensation." In *Marshall v. Snyder*, 1 EBC 1878 (E.D.N.Y., 1979), a salaried trustee was not allowed to receive a "severance benefit." In *Marshall v. Kelly*, 465 F. Supp. 341, (W.D.Ok., 1978), a trustee receiving full-time pay was not allowed to keep a \$9,000 sales commission for selling property owned by the plan. In *Donovan v. Daugherty*, 550 F. Supp. 390 (S.D.Ala., 1982), trustees receiving full-time pay were not allowed to receive additional "monthly payment" benefits.

The Secretary argues that respondent has not stated a cause of action because, under "typical arrangements" for employee benefit plans, such as an insured health plan where the insurer has discretionary authority to decide claims, or a plan under which a company employee has such authority and the employer pays claims out of its own assets, there is some measure of divided loyalty on the part of the claims decisionmaker. (Secretary Br. 28) The analogy does not hold. A third-party administrator whose individual income does not depend on the denial of claims is hardly analogous to an administrator who is a party in interest and whose income is based, in large part, upon denials. In the majority opinion, Justice Coffey correctly observed that, "[t]olerance, in other words, has its limits." 154 F.3d at 373.

The Secretary also argues that, if an HMO's business decisions, such as how to compensate physicians for their treatment of patients, where subject to ERISA fiduciary provisions, it is difficult to understand how the HMO could function as a business entity. (Secretary Br. 18) The Secretary has answered her own question. An HMO can easily make business decisions as to how to compensate its physicians by simply insuring that claims decisions are made by independent third-party administrators. Using the Secretary's own "typical arrangements" analogy, simply remove the claims administration function from the hands of any physicians whose income depends upon claim denials. Indeed, the simple expediency of using an independent third-party administrator was the very course suggested in *Donovan v. Bierwirth*, 680 F.2d 263 (2nd Cir.), *cert. denied*, 459 U.S. 1069 (1982) where the court advised the fiduciaries to seek "someone above the battle." *Donovan* at 272-273. This case would not be before this Court if the petitioners' claims administration was performed by anyone other than the physicians whose income depended on claims denials.

III. ERISA'S FIDUCIARY DUTIES ARE BASED ON THE COMMON LAW DUTY OF LOYALTY.

ERISA's fiduciary duties draw much of their content from the common law of trusts, the law that governed most benefit plans before ERISA's enactment. *Varity* at 496; H.R. Rep. No. 93-533, pp. 3-5, 11-13 (1973), 2 Legislative History of the Employment Retirement Income Security Act of 1974 (Committee Print compiled for the Senate Subcommittee on Labor of the Committee on Labor and Public Welfare by the Library of Congress), Ser. No. 93-406, pp. 2350-2352, 2358-2360 (1976). Rather than specifically enumerating all the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility. *Central States, S.E. & S.W. Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985). With respect to ERISA's fiduciary duties, courts are to apply common law trust standards "bearing in mind the special nature and purpose of employee benefit plans." H.R. Conf. Rep. No. 93-1280, p. 302, 3 Leg. Hist. 4569.

The bedrock concept that remains in all health plans governed by ERISA is that the Plan will have one or more fiduciaries who will manage the plan with loyalty and an "eye single" toward the interests of the plan participants. *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2nd Cir., 1982), cert. denied 459 U.S. 1069 (1982); Cantor, "Fiduciary Liability in Emerging Health Care," DePaul Bus. L.J., 189, 190 (1997). The "solely in the interest" standard is the most fundamental of ERISA's standards imposed by § 404(a)(1). Polk, *ERISA Practice & Litigation*, § 303(a) (West 1999 Supp.) Section 404(a)(1)(A) imposes a duty to act for the "exclusive purpose" of providing benefits and deferring reasonable administrative expenses, which is an extension of the common law duty of loyalty.

Central States at 570. To deter a trustee from all temptation and to prevent any possible injury to the beneficiary, the rule against a trustee dividing his loyalties must be enforced with "uncompromising rigidity." A fiduciary cannot contend that, although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of his secondary one. *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329 (1981).

Here the Court of Appeals correctly ruled that this duty of loyalty is directed particularly at schemes "tainted by a conflict of interest and thus highly susceptible to self-dealing." 154 F.3d at 371. The Court of Appeals specifically noted that, in the case at bar, members of the benefit plan's administrative review board "were the very owners of the plan, and plan beneficiaries were without a single representative on the board." 154 F.3d at 378. The court further noted that the Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of the cost savings. 154 F.3d at 372.²⁸

One of the overriding goals of ERISA is to prevent the misuse and mismanagement of plan assets by fiduciaries. See *Massachusetts Mutual Life Ins., Co. v. Russell*, 473 U.S. 134, 140 (1985). To achieve that goal, ERISA § 409(a), (29 U.S.C. § 1109(a)) requires a fiduciary to disgorge to an employee benefit plan, any profits made through improper use of plan assets. *Id.* Section 409(a) makes administrators liable

28. The court of appeals concluded that the self-dealing administrators here were no different than the broker who was guilty of "churning" the securities of a profit-sharing plan. *Dasler v. E.F. Hutton & Co., Inc.*, 694 F. Supp. 624 (D. Minn., 1988).

for breach of their fiduciary duties and specifies the remedies available against them, including restitution. ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)) defines the duty of loyalty in terms similar to those in the Restatement (Second) of Trusts. Under the Restatement, when a trustee breaches his duty of loyalty, the beneficiary may bring suit to recover any profits made through the breach.

The foresight of Congress in drawing upon the common law of trusts not only allows courts to fashion equitable remedies to address the wrong at hand, it also allows the courts to engage in specific analysis on a case by case basis. Given the incredible number of managed care organization permutations (i.e., HMOs, PPOs, IPAs, etc.) and given the wide variety within even those sub-categories, it is unlikely that a black-letter rule of law could offer the necessary protection to plan participants. Neither is it advisable to legislate specific guidelines, as the rapid pace of evolution of healthcare organizations would greatly outpace such guidelines. The beauty of the common law is that, like biblical parables, the themes are both fluid and timeless. Respondent respectfully suggests that this Court decline petitioners' invitation to place certain entities beyond the reach of ERISA's common law tenets.

CONCLUSION

The decision of the Court of Appeals should be affirmed.

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IN THE
Supreme Court of the United States

—
LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
and HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH
Respondent.

—
On Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

—
REPLY BRIEF OF PETITIONERS
—

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TABLE OF CONTENTS

	<i>Page</i>
TABLE OF AUTHORITIES	iii
INTRODUCTION	1
ARGUMENT	2
I. PETITIONERS DID NOT ACT AS FIDUCIARIES WHEN IMPLEMENTING THE COST- CONTAINMENT MECHANISM AT ISSUE	2
A. Petitioners' Cost-Containment Mechanism Is Not Governed By ERISA's Fiduciary Standards	2
B. Petitioners' Implementation Of The Cost- Containment Mechanism At Issue Is Not Fiduciary In Nature	7
II. HERDRICH FAILED TO STATE A CLAIM FOR FIDUCIARY BREACH	14
A. ERISA Fiduciaries May Possess Dual Loyalties	16
B. Petitioners' Cost-Containment Mechanism Is Not A Prohibited Transaction Within The Meaning Of Section 406 Of ERISA	17
C. Herdrich's Failure To Allege Damage To The Plan Demonstrates That She Failed To State A Claim For Fiduciary Breach Under Section 409(a) Of ERISA	19

CONCLUSION	20
------------------	----

TABLE OF AUTHORITIES

CASES

	<i>Page</i>
<i>Arizona v. California</i> , 460 U.S. 605 (1983)	14
<i>De Buono v. NYSA-ILA Med. & Clinical Servs. Fund</i> , 520 U.S. 806 (1997)	8
<i>Dukes v. U.S. Healthcare, Inc.</i> , 57 F.3d 350 (3d Cir. 1995)	9
<i>Kerns v. Benefit Trust Life Ins. Co.</i> , 992 F.2d 214 (8th Cir. 1993)	16
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	7
<i>Lopez v. Monterey County</i> , 119 S. Ct. 693 (1999)	3
<i>Martin v. Feilen</i> , 965 F.2d 660 (8th Cir. 1992)	16
<i>Molasky v. Principal Mut. Life Ins. Co.</i> , 149 F.3d 881 (8th Cir. 1998)	16
<i>New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.</i> , 514 U.S. 645 (1995)	4,9
<i>Pilot Life Ins. Co. v. Dedeaux</i> , 481 U.S. 41 (1987)	3

<i>UNUM Life Ins. Co. v. Ward</i> , 119 S. Ct. 1380 (1999)	3
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	3,4,8
<i>Yee v. City of Escondido</i> , 503 U.S. 519 (1992)	6

FEDERAL STATUTES

29 U.S.C. § 1002	<i>passim</i>
§ 1104(a)	17
§ 1106	17
§ 1108	18,19
§ 1109(a)	19
§ 1144	3,8

FEDERAL REGULATIONS

29 C.F.R. § 2509.75-8	5
42 C.F.R. § 417.479	10

CONGRESSIONAL HISTORY

H.R. 2990, 106th Cong. (1999)	5
S. 1344, 106th Cong. (1999)	5

INTRODUCTION

In her complaint, respondent Herdrich alleged that the petitioner health maintenance organization ("HMO") and its owner physicians implemented a cost-containment mechanism that provided the HMO's owner physicians with a supplemental payment at the end of the year if the HMO successfully contained costs while providing health care to its subscribers. She claimed that implementation of this mechanism breached petitioners' fiduciary duty under the Employee Retirement Income Security Act ("ERISA") because it gave CarleCare physicians a financial incentive to withhold treatment. See Resp. Br. 9 (the "*sole focus*" of her amended complaint is the "design and administration of an undisclosed physician incentive to withhold treatment") (emphasis supplied). The court of appeals concluded that these bare allegations sufficed to state a claim for fiduciary breach.

In our opening brief, we showed that the decision of the court of appeals should be reversed. For numerous reasons, petitioners were not acting as fiduciaries when they implemented the cost-containment mechanism at issue and, even if they were, the bare allegation that such a mechanism has been adopted fails to state a claim for breach of fiduciary duty under ERISA. In opposition, Herdrich first argues that financial incentives for cost containment are not good public policy. To be sure, there is ample room for disagreement -- and ample disagreement -- about the drawbacks and benefits to the public of managed care, including cost-containment mechanisms. That policy debate is not, however, the issue here. The sole issue is whether the implementation of a managed-care program which simply reflects the alignment of the financial interests of an HMO and its owner physicians is a breach of fiduciary duty under ERISA. On that question, we show *infra*, none of Herdrich's arguments has merit.

In an *amicus* brief, the government agreed that the court of appeals' decision should be reversed, albeit not on all grounds urged by petitioners. In the course of responding to Herdrich's arguments, we also address the government's points of disagreement with petitioners' analysis.

ARGUMENT

I. PETITIONERS DID NOT ACT AS FIDUCIARIES WHEN IMPLEMENTING THE COST-CONTAINMENT MECHANISM AT ISSUE.

A. Petitioners' Cost-Containment Mechanism Is Not Governed By ERISA's Fiduciary Standards.

1. As petitioners explained in their opening brief, and as Judge Easterbrook suggested below, an ERISA "plan" is *only* the "plan, fund, or program" that is "*established or maintained by [the] employer.*" 29 U.S.C. § 1002(1) (emphasis supplied). The sole benefit of the plan "established or maintained" by State Farm is *membership* in the CarleCare HMO. See Pet. Br. 24-26. And because the CarleCare HMO was not "established" and is not "maintained" by State Farm, the CarleCare HMO's internal decisions about the arrangement or provision of health care to its members are not decisions about a benefit offered under an ERISA "plan." Hence, ERISA does not apply to those decisions.

Respondent and the government, however, contend that the benefit provided by State Farm's ERISA plan is the specific package of medical services arranged by the CarleCare HMO. Neither comes to grip with the relevant statutory language or a legislative intention reflected in that language -- to protect employee benefits by placing limits on *employers'* ability arbitrarily to restrict or deny those benefits.

First, respondent and the government argue that this Court has already determined that, even when an employer provides benefits by purchasing an insurance product, the ERISA benefits are the specific benefits provided by the insurance policy, rather than the right to the policy. It maintains that this Court's decisions in *Pilot Life Insurance Co. v. Dedaux*, 481 U.S. 41 (1987), and *UNUM Life Insurance Co. v. Ward*, 119 S. Ct. 1380 (1999), establish that "the benefit offered in a traditional insured ERISA plan" is "the specific benefits offered under the insurance policy." Govt. Br. 24. See also Resp. Br. 34. Thus, the government asserts, it would make no sense to adopt a different rule for health insurance coverage offered through HMOs. Govt. Br. 24.

Petitioners' reading of 29 U.S.C. § 1002(1) is not in tension with the holdings of either *Pilot Life* or *UNUM*. In both cases, the parties *assumed* that the benefit offered by the ERISA "plan" included the specific benefits provided by the insurance policy purchased by the employer. The Court then proceeded on the basis of this assumption to determine whether state laws that regulated the processing of benefit claims by the insurance carrier were "saved" from federal preemption by another section of ERISA, 29 U.S.C. § 1144(b)(2), because they "regulat[ed] insurance." See *UNUM*, 119 S. Ct. at 1386-90; *Pilot Life*, 481 U.S. at 47-57. This Court did not reach out to address the validity of the parties' joint assumption, but that omission does not transform this assumption into a holding. Cf. *Lopez v. Monterey County*, 119 S. Ct. 693, 702 (1999) ("this Court is not bound by its prior assumptions") (citing *Brecht v. Abrahamson*, 507 U.S. 619, 630-31 (1993)).¹ This Court has

¹ Herdrich, but not the government, argues that petitioners' position -- that the sole "benefit" provided to her by the "employee welfare plan" in this case is HMO membership -- is also inconsistent with *Varsity Corp. v. Howe*, 516 U.S. 489 (1996). She contends that "employing this analysis, the employees of Massey Combines would have had no cause of action because

(continued...)

not yet decided how an employer's decision to provide benefits simply by arranging for the purchase of an insurance product and playing no further role affects the definition of the ERISA plan benefit provided.

In fact, extending ERISA beyond the employer-employee relationship to cover ordinary, arms-length commercial relationships such as the type at issue here would needlessly displace state law. Cf. *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 661 (1995) ("nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern"). In the government's view, when a business purchases insurance or an HMO membership for its employees, the insurance carrier or HMO is in some respects subject to ERISA's fiduciary requirements and must make certain decisions with an "eye single" to the interests of the claimant. And, state regulation would be displaced except where the insurance savings clause of ERISA applied. In contrast, if that same employee were to purchase the same insurance or HMO membership on his or her own, ERISA would not apply at all, and benefit disputes would be governed solely by state law. Thus, different regimes would govern insurers' and HMOs' conduct depending solely upon the source of payment for the coverage.

¹(...continued)

they still had membership in the Massey Combines nonpension benefits plan." Resp. Br. 34 (footnote omitted). But, in *Varity Corp.*, Varity Corporation was "both an employer and the benefit plan's administrator." 516 U.S. at 498 (emphasis omitted). Thus, the employee benefit was a package of particular health care benefits *established and maintained by the employer*. Here, in contrast, the employer's role ends once the HMO membership is purchased by the employer and employee payments.

Second, the government observes that the House of Representatives recently passed a bill that would eliminate ERISA preemption of some state-law causes of action for damages involving HMOs. Govt. Br. 25. It suggests that the bill would not be necessary if petitioners' position -- that HMO membership is the sole benefit provided by the ERISA plan -- were correct, because there would be no preemption to eliminate. In fact, however, the proposed legislation would eliminate preemption of such state-law claims not only with respect to HMOs, but also with respect to *all providers of "insurance, administrative services, or medical services" to a group health plan*. H.R. 2990, 106th Cong. § 1302(a) (1999) (emphasis supplied). Even the government acknowledges that the provision of "medical services" under a group health plan is not preempted, see Govt. Br. 12-14, and most laws regulating insurance are expressly saved from preemption by ERISA; yet preemption of claims relating to providers of medical services and insurance would also be eliminated under the bill. This bill clearly is intended broadly to eliminate ERISA preemption without regard to the nuances of federal courts' interpretation of ERISA's complex preemption provision. In any event, the Senate counterpart of this bill contains no comparable provision, S. 1344, 106th Cong. (1999), and the proposed bill is not law.²

² The government makes an analogous argument, citing Department of Labor regulations addressing activities that constitute plan administration within the meaning of section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). Govt. Br. 23. The regulations on their face prohibit the argument made by the government: "No inferences should be drawn regarding issues not raised which may be suggested by a particular question and answer . . ." 29 C.F.R. § 2509.75-8. More fundamentally, these regulations do not purport to define an ERISA "plan" and thus do not determine whether the benefit "established or maintained" by State Farm is membership in the CarleCare HMO.

Finally, respondent and the government suggest that the Court should not consider this argument because, at the petition stage, petitioners acknowledged that the specific medical services they provide are benefits of an ERISA plan. See Resp. Br. 21; Govt. Br. 26. Petitioners sought review of the broad question whether amended count III of the complaint stated a claim for breach of fiduciary duty under ERISA. The acknowledgments cited were made in the context of arguments that *assumed* that medical services are ERISA plan benefits and that showed nonetheless that petitioners were not acting as fiduciaries or breaching a fiduciary duty when they implemented the cost-containment mechanism at issue. Now that this Court is addressing the merits, petitioners have fully briefed, and this Court may consider, all arguments in support of their position that the complaint failed to state a claim under ERISA. See *Yee v. City of Escondido*, 503 U.S. 519, 534 (1992) (“[o]nce a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below”). Consideration of this argument is especially appropriate since it was addressed by Judge Easterbrook’s dissent from denial of rehearing *en banc*.

2. In any event, even assuming that the benefits under the State Farm plan are the particular medical services specified in the Group Subscription Certificate (as we do for the remainder of this reply), State Farm’s decision to arrange health-care benefits through the CarleCare HMO was a plan design decision not subject to ERISA’s fiduciary standards.

Herdrich is alleging that petitioners breached their fiduciary duty simply because the CarleCare HMO’s owners had a financial incentive to contain costs in order to receive additional earnings. A plan sponsor’s decision to provide health-care benefits through an HMO necessarily entails the implementation of cost-containment measures to reduce costs and increase earnings for the HMO and its owners. See Pet. Br.

26-28. It is therefore comprehended within the plan design decision and is not subject to ERISA’s fiduciary standards. See, e.g., *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996). Indeed, the Group Subscription Agreement, one of the plan documents of the plan at issue, expressly included the specific cost-containment measures alleged to constitute a fiduciary breach. Pet. Br. 28-29.

Herdrich’s sole response to this argument is that petitioners, not State Farm, designed and implemented the incentive scheme. Resp. Br. 22 n.14, 28. This misses the point. State Farm decided to provide benefits through the purchase of a particular product, membership in the CarleCare HMO. The alleged incentive scheme was inherent in the decision to choose the HMO as the service provider.³ Thus, the subject of Herdrich’s allegations is a plan design decision by State Farm, and ERISA’s fiduciary standards do not apply.

B. Petitioners’ Implementation Of The Cost-Containment Mechanism At Issue Is Not Fiduciary In Nature.

1. In her complaint, Herdrich alleges that petitioners were acting as fiduciaries when, in order to increase their annual earnings, they “contract[ed]” with CarleCare physicians to minimize diagnostic tests and the use of non-CarleCare facilities and to “determin[e] what was or was not medically necessary.”

³ Herdrich argues that “implementation decisions are fiduciary decisions.” Resp. Br. 28 (citing, e.g., *Waller v. Blue Cross of Cal.*, 32 F.3d 1337 (9th Cir. 1994)). In the cases cited, plan sponsors made plan termination decisions that were not subject to ERISA, but also left discretionary determinations to be made in the course of plan termination, and these determinations were deemed fiduciary because they directly affected plan benefits. In this case, the plan design decision necessarily entailed the cost-containment mechanism deemed objectionable by Herdrich. Moreover, unlike the decisions at issue in the implementation cases cited by Herdrich, none of the decisions here has any direct effect on plan benefits.

Resp. Br. 19. Both parties and the government agree that physicians' medical treatment decisions are not themselves fiduciary judgments within the meaning of ERISA. See *id.* at Br. 8-9, 24 n.16; Govt. Br. 11-13. As Herdrich explains, the "sole focus" of amended count III is the "design and administration of an undisclosed physician incentive to withhold treatment." Resp. Br. 9. The question for decision is thus whether an HMO is subject to ERISA's fiduciary standards when it establishes and implements a physician incentive to contain costs.

Thus, there is no dispute that when an HMO is providing or arranging for medical services, it is akin to any provider of services to an ERISA plan. It is neither administering nor managing an ERISA plan and thus is not acting as a fiduciary. See 29 U.S.C. § 1002(21)(A). As we described in our opening brief, any other result would virtually eliminate traditional state regulation of the practice of medicine. If ERISA were to govern the provision of health care to patients covered by ERISA plans, then state laws which govern the same area necessarily would "relate to" ERISA plans and be preempted under section 514(a), 29 U.S.C. § 1144(a). See also *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 & n.10 (1997) (where a state law is a "regulation of matters of health and safety," the "starting presumption" [is] against preemption").⁴

⁴ Herdrich points out that ERISA "expand[ed] the universe of persons subject to fiduciary duties." Resp. Br. 18 (emphasis omitted) (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993)). That is, of course, true, but ERISA also narrows the scope of a fiduciary's obligation by defining a person as a fiduciary only "to the extent" that he or she is making discretionary judgments about plan management or administration. 29 U.S.C. § 1002(21)(A). And, ERISA authorizes fiduciaries to possess dual loyalties while the common law of trusts forbids it. See, e.g., *Varity Corp.*, 516 U.S. at 498.

Conceding this, Herdrich nonetheless asserts that petitioners were administering an ERISA plan and thus acting as fiduciaries when they *contracted* with physicians under terms that might create an indirect incentive for the physician to withhold treatment. She is wrong. An HMO's decisions about how to compensate its physicians are part and parcel of its function as the arranger or provider of medical services. These decisions no more involve plan administration than do medical treatment decisions themselves. See, e.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 353, 360-61 (3d Cir. 1995) (holding that HMO's "selection, employment and oversight of . . . medical personnel" does not "relate to" an ERISA plan). Indeed, they are even more tenuously linked to plan administration: Medical treatment decisions may determine the nature of a benefit received pursuant to an ERISA plan, but physician compensation at best indirectly affects plan benefits. See Pet. Br. 32-35.

Moreover, state regulation of medical care extends well beyond direct regulation of treatment and "includes as well the means of compensation by which a doctor may be reimbursed for providing care to patients." Govt. Br. 17-18 & n.11 (citing state legislation addressing physician compensation). On Herdrich's view, all of this legislation would be preempted with respect to ERISA plans because ERISA governs contractual arrangements for medical services. That result would conflict with this Court's recent decisions holding that state laws regulating health care which have only an "indirect economic influence" on an ERISA plan are not preempted. See *Travelers Insurance Co.*, 514 U.S. at 659; *De Buono*, 520 U.S. at 815-16.

Finally, if an HMO's decisions about how to compensate physicians were subject to ERISA's fiduciary duty provisions, "it is difficult to understand how the HMO could function as a business entity." Govt. Br. 18. An HMO, by definition, has a

financial incentive to arrange for medical services at the least cost to itself, but, were ERISA to apply, it would be required to make compensation decisions (and numerous other operational decisions that might tangentially affect benefits) without any consideration of cost. There is nothing in ERISA that indicates a congressional intent to so cripple an HMO's ability to function as a business. Indeed, the HMO Act, which expressly authorizes HMOs to enter into risk-sharing arrangements with physicians, and other legislation strongly suggests a contrary congressional intent. See Pet. Br. 4-5.⁵

2. The government states, "to the extent the complaint in this case alleges that Carle Care physicians make discretionary decisions *in deciding claims*, it has alleged conduct that is fiduciary in nature." Govt. Br. 30-31 (emphasis supplied). And, the government continues, because some of the allegations "are phrased in terms of 'administering' the plan, rather than providing medical care, we do not read them to refer to a treating physician's determination of how to treat a patient, whether a course of treatment is sufficiently proven to be safe, or whether an emergency exists that calls for the use of particular medical emergency protocols." *Id.* at 32. Instead, the government reads the allegations to "refer to the claims administration process within the HMO, which is triggered when individuals or . . . treating physicians seek determination

⁵ Herdrich implies that Congress had made incentives of the sort alleged here unlawful in the Medicare program. Resp. Br. 13. That is entirely incorrect. In the Medicare context, title 42 of the C.F.R., section 417.479, forbids "specific payment" to a physician for failing to provide medically necessary services to an individual and establishes safeguards only where incentive plans place physicians at "substantial financial risk," as defined by the regulation. Neither condition is satisfied here. And, the Medicare regulation does not apply to the CarleCare HMO in any event.

of whether particular medical services are covered by the plan." *Id.* (parentheses omitted).

For two independent reasons, however, the government's argument -- that Herdrich may have successfully pled that petitioners were acting as fiduciaries in certain limited respects -- is wrong.

First, the government appears to have misread the complaint. Herdrich's complaint is not focused on CarleCare HMO administrators' particular denials of claims for benefits. As her brief to this Court makes plain, Herdrich's allegations pertain only to *implementation of a mechanism* that provides "physician incentive[s] to withhold treatment." Resp. Br. 9; see also *id.* (describing the "sole focus" of amended count III as the "design and administration of an undisclosed physician incentive to withhold treatment").

While Herdrich uses the word "administering" in amended Count III, her brief makes clear that she is not referring to claims "administration" as defined by the Govt. Br. 20-23 -- *i.e.*, the determination of individual claims for benefits made by someone other than a patient's personal physician. And she most certainly is not alleging that "petitioners [were] act[ing] in the role of claims decisionmakers" when they engaged in the conduct at issue. *Id.* at 27. No individual physician, be it a treating physician or a physician making claims determinations, is a defendant in amended count III. Herdrich is focused on the design and implementation of a cost-containment incentive by the HMO, not on decisions about individual claims. As we show *infra*, the former actions are not fiduciary in nature.

Equally to the point, Herdrich's allegations relate only to a mechanism that may affect the decisions of *treating physicians*. Specifically, she asserts that in the CarleCare HMO treating physicians have an incentive to withhold care when

confronted with a diagnostic or treatment decision that implicates coverage, the applicable standard of care, an experimental therapy, or whether an emergency exists. Pet. App. 86a. While she refers to both the decision to implement the incentive and the physicians' treatment decisions as plan "administration," they are not. They are, respectively, business and treatment decisions, not claims determinations.

Specifically, Herdrich explains that in amended count III, she is alleging that petitioners breached their fiduciary duties by "administering the plan by determining what was or was not medically necessary." Resp. Br. 19. Under the Group Subscription Certificate § 8.3, "[t]he determination of what is or is not medically necessary is left to the judgment of the Carle physicians." Herdrich is characterizing such treatment decisions as administrative because they implicate whether a patient will receive a particular service provided under an ERISA plan, but, for reasons already explained above, such decisions do not constitute plan "administration" within the meaning of section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). Herdrich's many statements explaining the allegations of amended count III and their "sole focus" on physician incentives to withhold treatment make plain that Herdrich's allegations concern the contracting for and implementation of incentives for physicians to withhold medical treatment from the patients under their care and not any claims administration process.

Second, Herdrich has not alleged that petitioners implemented a cost-containment mechanism that might give *administrators* (qua administrators, not personal physicians) some ownership or profit-sharing interest in the HMO and thus an indirect financial interest in the HMO's earnings. But, had she done so, she still would not have alleged that petitioners were acting as fiduciaries. Herdrich clearly did not allege that she or any other patient was wrongly denied a benefit under the plan through the claims administration process or otherwise.

She would instead be contending that petitioners put in place a cost-containment mechanism that provided some administrators with an ownership or profit-sharing interest in the HMO, thus giving them an indirect financial interest in the HMO's earnings and a tenuous incentive to deny claims.

We showed in our opening brief that this kind of business judgment, which has only an indirect effect on any plan benefit, should not be considered an act of plan administration or management and thus fiduciary in nature. Pet. Br. 32-36. All businesses, including health-care providers, seek to control costs; virtually any cost-saving mechanism may indirectly affect benefits. An HMO considers costs and earnings when it establishes an ownership structure and when it implements a compensation structure for its employees or independent contractors. Such decisions may, like many other business judgments, have some indirect effect on a benefit provided under an ERISA plan. But that cannot be the test for fiduciary status or the scope of fiduciary obligation will become unacceptably wide and vague, contravening the language, intent, and structure of ERISA, broadly preempting much state regulation of health-care providers, and discouraging HMOs and others from providing services to ERISA plans. *Id.*

In sum, amended count III does not make allegations involving the claim administration process as defined by the government. But even had Herdrich alleged that petitioners implemented a mechanism that might somehow indirectly affect claims administration, she failed to allege a fiduciary act. The implementation of business judgments that have only a potential, indirect effect on ERISA benefits does not constitute administration or management of a plan.⁶

⁶ Herdrich argues that petitioners are collaterally and judicially estopped from asserting that they are not fiduciaries, because that assertion allegedly "contradict[s] the representations they made in order to have this (continued...)

II. HERDRICH FAILED TO STATE A CLAIM FOR FIDUCIARY BREACH.

In our opening brief, we showed that allegations (i) that a CarleCare HMO physician's treatment decision might result in a cost savings for the HMO and (ii) that the same physician has some ownership interest in the HMO, do not state a claim for fiduciary breach. Pet. Br. 43-47. The government supported this analysis. See Govt. Br. 28-30.

The complaint at issue alleges only that CarleCare physicians may have conflicting financial loyalties with respect to plan beneficiaries because they are the owners of the CarleCare HMO.⁷ Congress has made clear, and this Court has emphasized, that an ERISA fiduciary may have and, indeed, may act on conflicting loyalties. Pet. Br. 44 (discussing 29

⁶(...continued)

case removed and preempted." Resp. Br. 26. Because she bases her argument on previous assertions in this same case, she is actually invoking the law of the case doctrine. See *Arizona v. California*, 460 U.S. 605, 618 (1983). That doctrine is discretionary, *id.*; and neither lower court addressed it or Herdrich's estoppel arguments.

Fundamentally, Herdrich's estoppel argument assumes incorrectly that if petitioners agreed that they were fiduciaries for one purpose, they must be fiduciaries for all purposes. When Herdrich added the original count III to her complaint, she asserted that petitioners *failed to disclose* certain material facts about the financial arrangements with physicians within the HMO in violation of state law. In response, and in this context, petitioners asserted that they were fiduciaries *for this purpose* (i.e., the disclosure of information related to their financial arrangements with physicians); that ERISA contained detailed disclosure requirements; and that the state-law claim was therefore preempted by ERISA. See Pet. App. 76a-79a. *With respect to the allegations of amended Count III -- the count at issue here -- petitioners have steadfastly maintained that they are not fiduciaries, and both parties and the courts have addressed this question on its merits.* In these circumstances, petitioners are not estopped from arguing that they are not fiduciaries.

⁷ See Complaint, amended count III, Pet. App. 85a-86a.

U.S.C. §§ 1108(c)(3); 1002(21)(A); *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996)). The existence of such conflicting loyalties (for example, here, a physician's loyalty to plan beneficiaries and to his or her financial interest) does not state a claim under ERISA for breach of fiduciary duty:

Under typical arrangements for employee benefit plans, such as an insured health plan where the insurance company has discretionary authority to decide claims, or a plan under which a company employee has such authority and the employer pays claims out of its own assets, there is some measure of divided loyalty on the part of a claims decisionmaker. *ERISA, however, tolerates the level of divided loyalty that is intrinsic to these common arrangements, so that ERISA plans will be created and insurance companies and others will find it practical to work for them.* [Govt. Br. 28 (emphasis supplied).]⁸

Herdrich does not dispute this analysis and effectively concedes (Resp. Br. 30-33) that her allegations amount to only "[t]he mere existence of . . . a potential conflict." Govt. Br. 28. She nonetheless contends that she has stated a claim for breach of fiduciary duty under ERISA. All of her arguments lack merit.

⁸ This point is the complete answer to any assertion that petitioners could avoid any ERISA difficulties by hiring independent plan administrators. Congress deliberately chose not to require ERISA fiduciaries to be free of all conflicts of interest in order to encourage the formation of ERISA plans.

A. ERISA Fiduciaries May Possess Dual Loyalties.

Herdrich first argues that although ERISA permits *plan sponsors* to operate in a dual capacity, it does not authorize other fiduciaries to do so. Resp. Br. 25. This is clearly wrong. ERISA defines a person as a fiduciary only "to the extent" that he or she has discretion with respect to plan management or administration. 29 U.S.C. § 1002(21)(A). The definition makes no distinction between plan sponsor fiduciaries and other fiduciaries, and there is no conceivable basis to engraft such a limitation onto the Act.

Indeed, Herdrich's interpretation of ERISA would make it virtually impossible for any bank, accounting firm, lawyer, or investment advisor ever to become an ERISA plan fiduciary. If she were correct, these entities would be required to make all business judgments -- not only those related to plan administration or management -- in the best interest of plan beneficiaries. And although Herdrich is "unaware of any cases in which dual capacity has been conferred upon any party other than a plan sponsor," Resp. Br. 25, the only cases on point expressly authorize non-sponsors to act as both fiduciaries and non-fiduciaries.⁹ Many other cases so hold by implication when they render a non-sponsor a fiduciary for a particular purpose.

⁹ See *Molasky v. Principal Mut. Life Ins. Co.*, 149 F.3d 881, 884-85 (8th Cir. 1998) (holding that insurance company was a fiduciary for purposes of claim review but not for purposes of notification of changes in the plan); *Kerns v. Benefit Trust Life Ins. Co.*, 992 F.2d 214, 217 (8th Cir. 1993) (holding that insurance company was a fiduciary for purposes of claim handling, but not for purposes of notification of a policy lapse); *Martin v. Feilen*, 965 F.2d 660, 669 (8th Cir. 1992) (holding that professional accountants were not fiduciaries "when providing the professional services for which they were hired," but were when they stepped outside that role and made decisions with respect to plan assets).

B. Petitioners' Cost-Containment Mechanism Is Not A Prohibited Transaction Within The Meaning Of Section 406 Of ERISA.

Although Herdrich's brief is far from clear on this point, she appears to argue that ERISA section 406, 29 U.S.C. § 1106, precludes dual loyalties (or "structural conflicts") for all fiduciaries except plan sponsors. Resp. Br. 31. She points out that section 406 categorically forbids certain types of transactions between a plan and a party-in-interest or a fiduciary even where such transactions neither result in a denial of plan benefits nor cause any harm to the plan. Moreover, she says, a fiduciary's duty of loyalty under section 404(a) of ERISA, 29 U.S.C. § 1104(a), cannot be understood without reference to section 406. From this, she concludes that section 404(a) of ERISA forbids all dual loyalties.

This argument runs contrary to ERISA's definition of fiduciary, as we have already shown. Moreover, it makes little sense on its own terms. As Herdrich points out, in section 406 Congress departed from the common law of trusts and made specifically defined conduct by fiduciaries unlawful even if that conduct did not in fact result in a denial of plan benefits or cause harm to an ERISA plan. See Resp. Br. 32-33 (acknowledging common law rule). Congress expressly *limited* such "per se" liability to the defined transactions set forth in section 406. And, elsewhere in ERISA (e.g., section 3(21)(A), 29 U.S.C. § 1002(21)(A)), Congress expressly authorized fiduciaries to have dual loyalties. Herdrich's suggestion -- the extension of the limited per se rule in section 406 to forbid all dual loyalties in fiduciaries (except plan sponsors) -- is thus contrary to the language and structure of ERISA.

Herdrich may be arguing that petitioners breached section 406; that a breach of 406 also breaches section 404(a); and therefore that petitioners breached their fiduciary duty. She

did not cite this provision in her complaint, nor was section 406 addressed by the courts or the parties below. But if Herdrich is so alleging, her premise -- that the year-end supplemental payments to CarleCare physicians are prohibited transactions under section 406 -- is wrong. Critically, to state a claim under section 406, Herdrich must allege a "transaction" involving "plan" assets. See 29 U.S.C. § 1108. But as explained in petitioners' opening brief (pp. 24-26, 48-50), this plan -- like many health-benefit plans and in contrast to pension-benefit plans -- has neither a trust nor any plan assets. The plan benefits are the health care coverage provided by the HMO. But see Part I.A.1. Thus, the transactions in question -- the supplemental payments to CarleCare physicians from CarleCare HMO earnings -- do *not* implicate any plan asset or trust.

Likewise infirm is Herdrich's apparent argument that the year-end supplemental payments must be considered per se illegal because they are "excessive compensation" precluded by section 408(c) of ERISA, 29 U.S.C. § 1108(c). Section 408(c) does not define the full range of acceptable compensation schemes under ERISA. Instead, it creates a legal exemption for certain fiduciary benefit and compensation schemes that would otherwise be prohibited transactions under section 406. See 29 U.S.C. § 1106(a) (making illegal certain transactions between a plan and a party in interest "[e]xcept as provided in section 1108 of this title"). Because the supplemental payments at issue are *not* prohibited transactions under section 406, they are lawful under ERISA whether or not they are otherwise exempted from section 406 by section 408(c).¹⁰

¹⁰ In any event, Herdrich is flatly wrong when she states that the supplemental payments would not qualify for protection under section 408(c)(2). That provision excepts from section 406 "reasonable compensation for services rendered, or for the reimbursement of expenses properly rendered and actually incurred . . . except that no person so serving who already receives full-time pay from an employer . . . shall receive compensation from such (continued...)

* * * *

An allegation that a fiduciary has dual loyalties does not suffice to state a claim for breach of fiduciary duty, and that is, at best, what Herdrich alleged here.

C. Herdrich's Failure To Allege Damage To The Plan Demonstrates That She Failed To State A Claim For Fiduciary Breach Under Section 409(a) Of ERISA.

Herdrich does not allege that she was individually deprived of benefits under the plan at issue and does not seek individual relief. Instead, she brings this action "on behalf of the Plan pursuant to 29 U.S.C. 1132(a)" for an alleged violation of section 409(a), 29 U.S.C. § 1109(a). Pet. App. 85a. She claims that she alleged damage to an ERISA plan under section 409(a) because she alleged that the plan at issue had financial assets and that petitioners wrongfully depleted those assets to make the year-end supplemental payments. *Id.* at 87a. See also Resp. Br. 23-24 (stating that premiums paid to an HMO are divided into "risk pools" to cover expenses and that these risk pools are plan assets).

¹⁰(...continued)

plan." 29 U.S.C. § 1108(c)(2). Herdrich asserts that the "[p]etitioners are excluded from protection under 408(c)(2) because they are already paid a salary as full-time employees of Carle Clinic and/or HAMP." Resp. Br. 36. But this argument reflects confusion as to whom Herdrich has sued in amended count III of her Complaint. "Neither Dr. Pegram, nor any other individual physician, is a party defendant in Amended Count III." *Id.* at ii (citing Pet. App. 83a). Rather, Herdrich sued *Carle Clinic and HAMP themselves*, and these corporate entities are plainly not "employees." App. 83a. Thus, Carle Clinic and HAMP do not "receive[] full-time pay from an employer" and are permitted to receive "compensation for services rendered" to the plan, if such earnings, indeed, are compensation within the meaning of section 408.

But, as set forth in our opening brief (pp. 48-50) and above, the benefits of this health plan are the health-care services to be provided, not a particular monetary benefit. Nor is there any trust fund from which benefits are financed. Hence the plan at issue has no assets. As the government explains, petitioners provide services to an ERISA plan, but they are not themselves an ERISA plan and the HMO's earnings are not the assets of an ERISA plan. Govt. Br. 10-11 & n.4. Herdrich's allegations of damage thus "make no sense in ERISA terms. The year-end payments were not plan assets in the first place, and their return to the HMO would not constitute reimbursement to an ERISA plan." *Id.* at 11 n.4.

Herdrich's inability to allege any damage to an ERISA plan demonstrates that she has failed to state a claim for fiduciary breach under ERISA section 409(a).

CONCLUSION

For the reasons set forth in our opening brief and above, the decision of the court of appeals should be reversed.

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In the Supreme Court of the United States CLERK

LORI PEGRAM, M.D., ET AL., PETITIONERS

v.

CYNTHIA HERDRICH

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

**BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONERS**

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QUESTION PRESENTED

Whether respondent, an enrollee in a health maintenance organization (HMO) offered through an employee welfare benefit plan, states a claim of breach of fiduciary duty under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, by alleging that the HMO has established an incentive arrangement under which a bonus is paid to physicians who (1) provide medical care in a manner that minimizes diagnostic tests and referrals to non-HMO facilities and non-HMO physicians and (2) determine whether disputed and non-routine health insurance claims are covered under the plan.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement	2
Introduction and summary of argument	7
Argument:	
A. An HMO is not itself an ERISA plan, although it may function at various times as the provider of medical services to such a plan or as administrator, and therefore fiduciary, of such a plan	9
B. Petitioners were not acting as fiduciaries under the "treatment" allegations of the complaint, because they allege only conduct that petitioners undertook as providers of medical services	16
C. The "administration" allegations of the complaint do state a claim that petitioners were acting in a fiduciary capacity, but they allege conduct that does not, as a matter of law, violate any fiduciary duty under ERISA	20
Conclusion	30

TABLE OF AUTHORITIES

Cases:

<i>Alessi v. Raybestos-Manhattan, Inc.</i> , 451 U.S. 504 (1981)	13
<i>Anderson v. Humana, Inc.</i> , 24 F.3d 889 (7th Cir. 1994)	12
<i>Bailey v. Blue Cross & Blue Shield of Virginia</i> , 67 F.3d 53 (4th Cir. 1995), cert. denied, 516 U.S. 1159 (1996)	22
<i>Boggs v. Boggs</i> , 520 U.S. 833 (1997)	13

IV

Cases—Continued:	Page
<i>Cannon v. Group Health Serv., Inc.</i> , 77 F.3d 1270 (10th Cir.), cert. denied, 519 U.S. 816 (1996)	22
<i>Conley v. Gibson</i> , 355 U.S. 41 (1957)	8
<i>Corcoran v. United Healthcare, Inc.</i> , 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992)	26
<i>De Buono v. NYSA-ILA Med. & Clinical Servs.</i> <i>Fund</i> , 520 U.S. 806 (1997)	13-14, 17
<i>Donovan v. Bierwirth</i> , 680 F.2d 263 (2d Cir.), cert. denied, 459 U.S. 1069 (1982)	5, 28-29
<i>Donovan v. Dillingham</i> , 688 F.2d 1367 (11th Cir. 1982)	10
<i>Doyle v. Paul Revere Life Ins., Co.</i> , 144 F.3d 181 (1st Cir. 1998)	28
<i>Dukes v. U.S. Healthcare, Inc.</i> , 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995)	11, 14, 17
<i>Englehardt v. Paul Revere Life Ins. Co.</i> , 139 F.3d 1346 (11th Cir. 1998)	22
<i>Firestone Tire & Rubber Co. v. Bruch</i> , 489 U.S. 101 (1989)	7, 28
<i>Fort Halifax Packing Co. v. Coyne</i> , 482 U.S. 1 (1987)	13, 15
<i>Grimo v. Blue Cross/Blue Shield</i> , 34 F.3d 148 (2d Cir. 1994)	10
<i>Group Life & Health Ins. Co. v. Royal Drug Co.</i> , 440 U.S. 205 (1979)	11
<i>Hughes Aircraft Co. v. Jacobson</i> , 119 S. Ct. 755 (1999)	1, 15
<i>Ingersoll-Rand Co. v. McClendon</i> , 498 U.S. 133 (1990)	13
<i>Kenney v. Roland Parson Contracting Corp.</i> , 28 F.3d 1254 (D.C. Cir. 1994)	10
<i>Kuhl v. Lincoln Nat'l Health Plan, Inc.</i> , 999 F.2d 298 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994)	22

V

Cases—Continued:	Page
<i>Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio</i> , 982 F.2d 1031 (6th Cir.), cert. denied, 510 U.S. 819 (1993)	22
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	15
<i>Lordmann Enters., Inc. v. Equicor, Inc.</i> , 32 F.3d 1529 (11th Cir. 1994), cert. denied, 516 U.S. 930 (1995)	16
<i>Lupo v. Human Affairs Int'l Inc.</i> , 28 F.3d 269 (2d Cir. 1994)	14
<i>Mertens v. Hewitt Assocs.</i> , 508 U.S. 248 (1993)	1, 11
<i>New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.</i> , 514 U.S. 645 (1995)	7, 14, 21
<i>Pacificare of Okla., Inc. v. Burrage</i> , 59 F.3d 151 (10th Cir. 1995)	13
<i>Parrino v. FHP, Inc.</i> , 146 F.3d 699 (9th Cir.), cert. denied, 119 S. Ct. 510 (1998)	22
<i>Pilot Life Ins. Co. v. Dedeaux</i> , 481 U.S. 41 (1987)	21
<i>Rice v. Panchal</i> , 65 F.3d 637 (7th Cir. 1995)	14
<i>Texas Pharmacy Ass'n v. Prudential Ins. Co.</i> , 105 F.3d 1035 (5th Cir.), cert. denied, 522 U.S. 820 (1997)	12
<i>Tregoning v. American Community Mut. Ins. Co.</i> , 12 F.3d 79 (6th Cir. 1993), cert. denied, 511 U.S. 1082 (1994)	22
<i>Turner v. Fallon Community Health Plan</i> , 127 F.3d 196 (1st Cir. 1997), cert. denied, 118 S. Ct. 1512 (1998)	22
<i>UNUM Life Ins. Co. v. Ward</i> , 119 S. Ct. 1380 (1999)	21, 22
<i>U.S. Healthcare, Inc., In re</i> , No. 98-5222, 1999 WL 728474 (3d Cir. Sept. 16, 1999)	11, 13, 17
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	1, 11, 14, 15

VI

Cases—Continued:	Page
<i>Washington Physicians Serv. Ass'n v. Gregoire</i> , 147 F.3d 1039 (9th Cir. 1998), cert. denied, 119 S. Ct. 1033 (1999)	12
Statutes, regulations and rules:	
Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 <i>et seq.</i>	1, 7
Tit. I, 29 U.S.C. 1001 <i>et seq.</i> :	
§ 302(1), 29 U.S.C. 1002(1)	10
§ 302(13), 29 U.S.C. 1002(13)	1
§ 302(21)(A), 29 U.S.C. 1002(21)(A)	12, 15
§ 404, 29 U.S.C. 1104	4
§ 404(a)(1), 29 U.S.C. 1104(a)(1)	7
§ 404(a)(1)(A), 29 U.S.C. 1104(a)(1)(A)	18
§ 404(a)(1)(A)(i), 29 U.S.C. 1104(a)(1)(A)(i)	7
§ 408(c), 29 U.S.C. 1108(c)	9, 28
§ 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B)	28
§ 506(b), 29 U.S.C. 1136(b)	1
§ 514, 29 U.S.C. 1144	21
§ 514(a), 29 U.S.C. 1144(a)	3, 13
§ 711(b)(4), 29 U.S.C. 1185(b)(4) (Supp. III 1997)	19
§ 733(a)(1), 9 U.S.C. 1191b(a)(1) (Supp. III 1997)	19
§ 733(a)(2), 29 U.S.C. 1191b(a)(2) (Supp. III 1997)	19
McCarran-Ferguson Act, 15 U.S.C. 1012	12
Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603, 110 Stat. 2935	19
Public Health Service Act, 42 U.S.C. 300e	23
Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, 112 Stat. 2681:	
§ 902(a):	
112 Stat. 2681-436 (to be codified at 29 U.S.C. 1185b(a))	19
112 Stat. 2681-437 (to be codified at 29 U.S.C. 1185b(c)(2))	19
42 U.S.C. 1395w-22(j)(4) (Supp. III 1997)	20
42 U.S.C. 1396b(m)(2)(A)(x) (Supp. III 1997)	20

VII

Statutes, regulations and rules—Continued:	Page
Alaska Stat. § 21.86.150(i)(4) (Michie 1998)	18
Cal. Health & Safety Code § 1348.6 (West Supp. 1999)	18
Ga. Code Ann. § 33.20A-6 (Supp. 1996)	18
Idaho Code § 41-3928 (1998)	18
Illinois Consumer Fraud and Deceptive Business Practices Act, 815 Ill. Comp. Stat. Ann. § 505/1 (West 1999)	2
Kan. Stat. Ann. § 40-4605 (Supp. 1998)	18
La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999)	18
Md. Code Ann. Ins. § 15-113(c) (1997)	18
Minn. Stat. § 72A.20 Subd. 33 (1999)	18
Mo. Rev. Stat. § 354.606(9) (Supp. 1999)	18
Mont. Code Ann. § 33-36-204(2) (1997)	18
Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998)	18
Nev. Rev. Stat. § 695G.260 (1998)	18
Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998)	18
40 Pa. Cons. Stat. Ann. § 991.2112 (West Supp. (1999)	18
R.I. Gen. Law § 23-17.13-3(B)(8) (1996)	18
Tex. Ins. Code Ann. § 3.70-3C(7)(d) (West Supp. 1999)	18
29 C.F.R.:	
Section 2509.75-8	26
Section 2560.503-1	23
Section 2560.503-1(c)	23
Section 2560.503-1(d)(3)	23
Section 2560.503-1(f)	23
Section 2560.503-1(g)(2)	23
Section 2560.503-1(j)	23
42 C.F.R. 434.70(a)(2)	20
Fed. R. Civ. P. 12(b)(6)	4

VIII

Miscellaneous:	Page
American Medical Ass'n, Council on Ethical and Judicial Affairs, <i>Code of Medical Ethics</i> (1998- 1999 ed.)	17
145 Cong. Rec.:	
p. S8623 (daily ed. July 15, 1999)	25
p. H9523-01 (daily ed. Oct. 7, 1999)	25
p. H11,341 (daily ed. Nov. 2, 1999)	25
63 Fed. Reg. (1998):	
p. 48,390	23
p. 48,391	23
p. 48,405	23
p. 48,406	23
H.R. Res. 348, 106th Cong., 1st Sess. (1999)	25
Patients' Bill of Rights Plus Act, S. 1344, 106th Cong., 1st Sess. (1999)	25
Quality Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong., 1st Sess. (1999)	20, 25

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**BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONERS**

INTEREST OF THE UNITED STATES

This case presents questions concerning the fiduciary status and duties under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, of a health maintenance organization (HMO) that provides medical care to members enrolled through an employee welfare benefit plan and that maintains incentives for HMO physicians to implement cost-containment measures. The Secretary of Labor has primary responsibility for enforcing and administering Title I of ERISA, including its fiduciary duty provisions. 29 U.S.C. 1002(13), 1136(b). Accordingly, the United States has a substantial interest in the case. The United States has participated in many other ERISA cases in this Court, including cases that have addressed the nature and scope of fiduciary duties under ERISA, such as *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); and *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993).

STATEMENT

1. State Farm Insurance Company maintains a Group Medical Health Plan (the State Farm Plan) for its employees, under which eligible employees may choose a group medical insurance plan or, "as an alternative health care choice," a health maintenance organization (HMO). J.A. 101. Respondent Cynthia Herdrich is married to a State Farm employee who enrolled in an HMO, Carle Care HMO, offered under the State Farm Plan. Pet. App. 84a.

The Carle Care HMO is "a product of" petitioner Health Alliance Medical Plans (HAMP), a for-profit Illinois domestic stock insurance corporation. Pet. App. 84a, 93a. HAMP, in turn, is a wholly-owned subsidiary of petitioner Carle Clinic Association, an Illinois professional medical corporation owned by its physician shareholders. HAMP contracts with Carle Clinic to furnish the medical services provided by the HMO. *Id.* at 86a. The net effect of this arrangement is that the physicians who provide care through the HMO are also the owners of the HMO.

2. Respondent sought treatment for abdominal pain from petitioner Laurie Pegram, a Carle Clinic physician, who scheduled her for an ultrasound procedure eight days later at a distant hospital affiliated with the HMO. Pet. App. 2a n.1, 23a-24a. Respondent's appendix ruptured in the interim, resulting in peritonitis. *Id.* at 2a n.1. Respondent then brought a two-count complaint in Illinois state court alleging medical negligence by Pegram and seeking to hold Carle Clinic liable under the doctrine of respondeat superior. *Id.* at 3a, 66a.

Subsequently, respondent amended her state court complaint to add a claim (Count III) against Carle Clinic, alleging that it violated the Illinois Consumer Fraud and Deceptive Business Practices Act, 815 Ill. Comp. Stat. Ann. § 505/1 (West 1999), by failing to advise her of material facts

regarding the ownership of HAMP and by failing to inform her that the compensation of the HMO's physicians was increased to the extent they did not order diagnostic tests, did not utilize facilities not owned by Carle Clinic, and did not make emergency or consultation referrals. Pet. App. 3a & n.2. She also brought a claim against HAMP (Count IV) alleging that by implementing those cost-containment measures, HAMP breached its state-law duty of good faith and fair dealing. *Ibid.*

Petitioners removed the case to federal court, on the ground that Counts III and IV were completely preempted by ERISA. Pet. App. 2a, 3a. The district court thereupon ruled that both counts were preempted and granted summary judgment on Count IV, but it gave respondent leave to amend Count III. *Id.* at 80a.¹

Respondent then amended Count III to assert the claim now at issue, *i.e.*, that HAMP and Carle Clinic breached fiduciary duties under ERISA.² Respondent alleged that petitioners had the exclusive right to decide all disputed and non-routine claims under "the Plan," which she defined as

¹ The district court ruled that Count IV was preempted and could not properly be amended to state an ERISA claim because respondent sought extra-contractual damages that were not available under ERISA. Pet. App. 67a-68a, 70a-76a. The court also ruled that Count III "relate[d] to" an employee welfare benefit plan, 29 U.S.C. 1144(a), and thus was preempted because it sought to impose additional disclosure requirements on an ERISA plan administrator under state law in addition to those expressly enumerated in ERISA's comprehensive disclosure scheme. Pet. App. 76a-80a. As explained below, when respondent subsequently amended Count III to assert a fiduciary breach claim under ERISA, the amendment did not allege any failure to disclose information.

² Respondent also brought her fiduciary breach claim against Carle Health Insurance Management Co., Inc. (CHIMCO), a management entity, which like HAMP is alleged to be a wholly owned subsidiary of Carle Clinic. Pet. App. 84a. CHIMCO is not a petitioner in this Court.

the Carle Care HMO,³ and exercised discretionary control of claims management, property management, and administration of "the Plan." Pet. App. 85a.

On the basis of those factual allegations, respondent asserted that petitioners breached fiduciary duties under Section 404 of ERISA, 29 U.S.C. 1104, because Carle Clinic physicians receive a year-end distribution paid out of "supplemental medical expense payments" that HAMP and CHIMCO pay to Carle Clinic based on contractual provisions requiring the physicians to minimize the use of diagnostic tests, of facilities not owned by Carle Clinic, and of referrals to "non-contracted" physicians. Pet. App. 85a-86a. Respondent also asserted that petitioners sought to fund the year-end payments by "administering disputed and non-routine health insurance claims," and determining, *e.g.*, "which claims are covered under the Plan and to what extent" and "what the applicable standard of care is." *Id.* at 86a. Respondent alleged that "the Plan" had been wrongfully deprived of amounts comprising the supplemental medical expense payments made by HAMP and CHIMCO to Carle Clinic and sought an order requiring reimbursement by Carle Clinic of the supplemental medical expense payments received from HAMP and CHIMCO as well as such other equitable relief as the court deemed just. *Id.* at 87a.

Petitioners moved to dismiss amended Count III under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. The district court granted the motion on the ground that respondent had "fail[ed] to identify how any of the [petitioners] is involved as a fiduciary to the Plan." Pet. App. 63a (magistrate's report); see *id.* at 59a-60a (adopting magistrate's report). Respondent's state-law medical malpractice claims were

³ As we explain below, pp. 9-11, *infra*, respondent's use of the term "plan" to refer to the HMO differs from the term's meaning under ERISA.

then tried to a jury, which rendered a \$35,000 verdict in her favor. *Id.* at 6a, 81a-82a. After entry of final judgment, respondent appealed the dismissal of her ERISA fiduciary breach claim.

3. a. A divided panel of the court of appeals reversed. Pet. App. 1a-38a. The panel majority held that respondent had adequately alleged that petitioners were fiduciaries. *Id.* at 11a-15a. Noting that the complaint alleges that petitioners "have the exclusive right to decide all disputed and non-routine claims under the plan," the court concluded that "this level of control satisfies ERISA's requirement that a fiduciary maintain 'discretionary control and authority.'" *Id.* at 14a (emphasis omitted).

The panel majority also held that respondent's allegations, if accepted as true, were sufficient to demonstrate that petitioners breached their fiduciary duty because they acted in their own interest, rather than "with an eye single to the interests of the [plan's] participants and beneficiaries." Pet. App. 16a (quoting *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.), cert. denied, 459 U.S. 1069 (1982)). The court noted that the complaint alleged that the plan "dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings," thus creating the incentive for them to limit treatment to ensure a larger bonus. *Id.* at 18a-19a (emphasis omitted).

The majority stated that it was not adopting a per se rule "that the existence of incentives *automatically* gives rise to a breach of fiduciary duty," but only that such "incentives *can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists." Pet. App. 20a. Addressing the dissent's view that imposition of incentives to limit care should con-

stitute a fiduciary breach only when there is a "serious flaw" in the manner in which the incentive arrangement is established, the majority concluded that there was such a flaw in that the "physician/owners of Carle * * * simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals." *Id.* at 21a (emphasis omitted). The majority referred to the treatment of respondent's appendicitis as an example of the effects of the incentive scheme, *id.* at 24a, 32a-33a, and expounded its view that managed care is having a deleterious effect on the quality of health care in this country, *id.* at 24a-33a.

Finally, the majority concluded that respondent alleged a loss to the plan attributable to the petitioners' alleged breach, in that the plan was deprived of the amounts paid as incentives. Pet. App. 38a. Accordingly, the majority concluded that respondent had alleged the requisite elements of a claim for fiduciary breach under ERISA.

b. Judge Flaum dissented. Pet. App. 38a-47a. In his view, respondent's allegations about the structural incentives for cost containment did not in themselves make out a case of fiduciary breach, because ERISA tolerates some conflict of interest on the part of ERISA fiduciaries, as by permitting the employer or plan sponsor's officer or employee to serve as fiduciary. *Id.* at 40a. The mere existence of such incentives was not enough, in his view, to establish a fiduciary breach because market forces protect the interests of beneficiaries by making it unlikely that the HMO would wish to alienate the employer-sponsor by maintaining an unduly restrictive approach to coverage. *Id.* at 40a-42a. Moreover, Judge Flaum stated his concern that the majority's decision would lead to "untethered judicial assessments of permissible incentive levels in health care plans." *Id.* at 44a.

4. The court of appeals denied rehearing en banc. Pet. App. 48a-49a. Judge Easterbrook, joined by three other

judges, filed an opinion dissenting from the denial of rehearing. *Id.* at 49a-58a. Judge Easterbrook concluded that Carle Care's decision to establish one set of cost-saving incentives rather than another is not an exercise of discretion in the administration of the employee benefit plan, but rather is an exercise of discretion by Carle Care in providing medical services. *Id.* at 52a-53a. He deemed respondent's complaint to allege that the benefit offered by State Farm to its employees was the Carle Care HMO, in which petitioners are acting as suppliers of a service to the plan, not plan fiduciaries. *Id.* at 56a. Judge Easterbrook also stated that in his view the majority's rule was "impossible to cabin, for the plan attacked in this case is an ordinary HMO." *Id.* at 56a.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, "was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' * * * and 'to protect contractually defined benefits.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989). The statute thus does not "requir[e] employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, * * * as by imposing reporting and disclosure mandates, * * * participation and vesting requirements, * * * funding standards, * * * and fiduciary responsibilities for plan administrators." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995). Among the various duties that ERISA imposes on fiduciaries of employee benefit plans is a duty of loyalty, under which a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. 1104(a)(1); see also 29 U.S.C. 1104(a)(1)(A)(i).

The court of appeals held that respondent stated a claim of breach of the duty of loyalty owed by a fiduciary by alleging that petitioners provided profit-based financial incentives for HMO physicians. Liberally read, as they must be in the context of a motion to dismiss for failure to state a claim, *Conley v. Gibson*, 355 U.S. 41 (1957), respondent's allegations challenge a bonus ("year-end distribution") allegedly paid by petitioner HAMP to Carle Clinic physicians that is "fund[ed]" by profits derived from two types of conduct. Pet. App. 86a. The first type is the provision of medical services by "owner/physicians" who allegedly "minimize the use of diagnostic tests," "minimize the use of facilities not owned by Carle," and "minimize the use of emergency and non-emergency consultation and/or referrals" to non-HMO physicians. *Ibid.* The second type is "administering disputed and non-routine health insurance claims." *Ibid.*

The first of these allegations—the "treatment" allegations—fails to state a claim because it does not allege conduct by petitioners in their capacity as ERISA fiduciaries. An HMO acts as a medical care provider, rather than an ERISA fiduciary, when it establishes and implements an arrangement for paying its physicians to treat their patients, even if the arrangement includes incentives for using less costly treatment regimens. If the court of appeals were correct that the law of fiduciary duty under ERISA governed the treatment of patients by HMO doctors, then traditional state regulation of the practice of medicine—along with traditional state-law malpractice and professional licensing regulations—would necessarily be preempted insofar as they applied to ERISA plans. In *Travelers* and subsequent cases, this Court has rejected that overly expansive view of ERISA's scope, and it should do so again here.

By contrast, the activities involved in the second set of allegations—the "administration" allegations—may involve conduct by petitioners as ERISA fiduciaries, because an

entity such as an HMO that exercises discretion in determining whether claims for specific benefits are covered by an ERISA plan is an ERISA fiduciary. Respondent, however, has alleged only that petitioners generate income by performing their roles as fiduciaries under ERISA. That allegation is insufficient to state a claim of breach of fiduciary duty under ERISA, because fiduciaries under ERISA are expected to be compensated for the performance of their duties. Cf. 29 U.S.C. 1108(c). Indeed, even if the complaint could be read to include an allegation that petitioners employ a profit-based system that permits those who assist in claims administration to share in the petitioners' general profits, it would still fail to state a claim of breach of fiduciary duty under ERISA. Unlike an incentive scheme in which claims administrators are directly paid for denying (but not for allowing) claims, a general profit-based compensation arrangement does not in itself conflict with the duties owed by fiduciaries under ERISA. Because none of respondent's allegations therefore states a claim of breach of fiduciary duty under ERISA, the decision of the court of appeals should be reversed.

ARGUMENT

A. An HMO Is Not Itself An ERISA Plan, Although It May Function At Various Times As The Provider Of Medical Services To Such A Plan Or As Administrator, And Therefore Fiduciary, Of Such A Plan

1. In order to determine whether an entity acts as an ERISA fiduciary, it is critical to distinguish between the ERISA plan itself (the administration of which by either the plan sponsor or an outside entity confers fiduciary status on an individual or other entity) and a provider of services to the plan (usually an independent entity not subject to ERISA's fiduciary duty standards). ERISA defines an "employee welfare benefit plan" as "any plan, fund, or

program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits" or other benefits. 29 U.S.C. 1002(1). Based on that definition, the essentials of a plan have been interpreted to be the existence of "intended benefits, a class of beneficiaries, [a] source of financing, and procedures for receiving benefits." *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982); accord *Grimo v. Blue Cross/Blue Shield*, 34 F.3d 148, 151 (2d Cir. 1994); *Kenney v. Roland Parson Contracting Corp.*, 28 F.3d 1254, 1257-1258 (D.C. Cir. 1994) (collecting cases).

2. In this case, the ERISA plan was the arrangement by which State Farm Insurance, respondent's husband's employer, undertook to provide medical care benefits to eligible employees and their families. See J.A. 51-52, 101 (Summary Plan Description of State Farm Group Medical Health Plan, which includes a group medical insurance option and HMO options). As to employees who opt for the Carle Care HMO option, the plan consists of the documents governing State Farm's purchase from HAMP of memberships in the HMO, and the "intended benefit[.]" *Dillingham*, 688 F.2d at 1373, under the ERISA plan is coverage for the specific kinds of medical care and treatment specified in the subscription agreement between State Farm and the HMO, Pet. App. 89a-128a. That care in turn is provided by the doctors employed by the HMO. The HMO and its parent entities are thus service providers to the ERISA plan; they are not themselves ERISA plans.

3. Because the HMO and its parent entities are not themselves ERISA plans, not all the acts that constitute management of the HMO are acts that constitute administration of an ERISA plan, to which ERISA fiduciary duties may

attach.⁴ To the contrary, in determining whether an HMO is acting as a fiduciary, two major roles in which an HMO typically acts must be distinguished. An HMO typically performs (at least) two distinct functions in the context of an employee welfare benefit plan—providing medical services to beneficiaries and administering certain aspects of the plan. See, e.g., *In re U.S. Healthcare, Inc.*, No. 98-5222, 1999 WL 728474, at *8 (3d Cir. Sept. 16, 1999); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir.), cert. denied, 516 U.S. 1009 (1995).⁵ Those functions lead to differing conclusions regarding an HMO's status as an ERISA fiduciary.

⁴ Because the HMO is not the ERISA plan, the court of appeals erred in suggesting, Pet. App. 16a, 36a, that petitioners here had control over the assets of an employee welfare benefit plan. State Farm and its employees paid a premium to HAMP for subscription in the HMO, J.A. 103; there is therefore apparently no underlying trust funding the ERISA plan. The assets referred to in the complaint belong either to HAMP or Carle Clinic, not to an ERISA plan. The allegation that HAMP made supplemental payments to Carle Clinic, which in turn funded payments to physicians, therefore states nothing more than that HAMP used its own funds as a business entity for that purpose.

It also follows that respondent's allegation (Pet. App. 87a) that "the Plan" has been deprived of the "supplemental medical expense payments," and her corresponding request that petitioners therefore should make reimbursement (presumably to "the Plan") for those expenses, make no sense in ERISA terms. The year-end payments were not plan assets in the first place, and their return to the HMO would not constitute reimbursement to an ERISA plan. Respondent also has sought "such other equitable relief as th[e] court deems just." *Id.* at 87a. If she were to establish that the incentive arrangement was incompatible with ERISA's fiduciary duty provisions, she could obtain a prospective injunction against the arrangement insofar as it affected ERISA plan participants. In addition, to the extent she was adversely affected by the incentive arrangement, she could obtain individual equitable relief, such as the disgorgement of the fiduciary's profits obtained by the breach committed as to her. *Variety Corp. v. Howe*, 516 U.S. 489, 507 (1996); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 260 (1993).

⁵ An HMO also acts as insurer to the extent that it bears risk. See generally *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 227 n.34 (1979) (noting that "certain aspects" of advance-payment medical-

a. Insofar as an HMO is a provider of medical services, it is no more subject to ERISA fiduciary duty standards than is any other provider of services to an ERISA plan. Under ERISA, a person is a fiduciary if "he exercises any discretionary authority or discretionary control respecting management of [an ERISA] plan * * * or control respecting management or disposition of its assets," if "he renders investment advice * * * with respect to any moneys or other property of such plan," or if "he has any discretionary authority or discretionary responsibility in the administration of [the ERISA] plan." 29 U.S.C. 1002(21)(A). A provider of medical treatment to a patient does not fall within any of those categories. Accordingly, an HMO, in its role as provider of medical treatment to patients who are beneficiaries of ERISA plans, is not an ERISA fiduciary.⁶

benefits plans may be the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012). See also *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1045, 1046 (9th Cir. 1998), cert. denied, 119 S. Ct. 1033 (1999); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994). But see *Texas Pharmacy Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035, 1038-1039 (5th Cir.), cert. denied, 522 U.S. 820 (1997).

⁶ In some cases, a treating physician in an HMO could exercise administrative duties that are clearly distinct from his treatment responsibilities and that therefore potentially subject him to ERISA fiduciary standards when he is exercising those administrative duties. For example, it is possible that a physician who believes that a particular treatment is medically advisable for a patient has the discretionary administrative responsibility within an HMO for determining whether a claim for such treatment is covered by the ERISA plan. Even if a treating physician may in some circumstances occupy such a dual role, however, that dual role would not be triggered merely because the standards that govern the physician's ordinary treatment decisions—medical necessity, the existence of an emergency, etc.—are also the standards governing the HMO's obligation to provide or pay for care for the patient. Otherwise, every treating physician would automatically become an ERISA fiduciary whenever the physician makes a medical judgment about the appropriate care for a patient. Respondent in this case did not allege that any particular circumstances that would trigger such a dual role existed in this case. Therefore, the question whether and to what extent a physician may

Were it otherwise, ERISA would threaten to carve out an enormous hole in traditional state regulation of the practice of medicine and other analogous professions. For if ERISA fiduciary duty obligations governed HMOs in their capacity as providers of medical treatment to patients covered by ERISA plans (as opposed to their capacity as claims administrators, for example), then state laws that govern the same thing—the practice of medicine by HMOs—would necessarily "relate to" ERISA plans and would be preempted under Section 514(a) of ERISA, 29 U.S.C. 1144(a). Indeed, the clearest cases of preemption under ERISA occur when a state law attempts to impose standards on an entity that differ from those imposed by ERISA. See, e.g., *Boggs v. Boggs*, 520 U.S. 833, 841 (1997) (holding state community property law preempted because it "conflicts with the provisions of ERISA or operates to frustrate its objects"); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (state-law cause of action for wrongful discharge to avoid pension obligation "conflicts directly" with ERISA causes of action and is therefore preempted).⁷ The courts of appeals, however, have correctly held that state laws governing the practice of medicine by HMOs are not preempted by ERISA.⁸ As this Court explained in *De Buono v. NYSA-*

occupy a dual role as treating physician and administrator of an ERISA plan is not presently before the Court.

⁷ See also *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) ("We have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements."); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (state law that "eliminates one method for calculating pension benefits * * * that is permitted by federal law" is preempted).

⁸ See *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 154-155 (10th Cir. 1995) (ERISA Section 514(a) does not preempt state-law action seeking to impose vicarious liability on HMO for malpractice of HMO physician); cf. *U.S. Healthcare, Inc.*, 1999 WL 728474, at *8-*9 (state-law

ILA Medical & Clinical Services Fund, 520 U.S. 806, 814 & n.10 (1997), the fact that a state law is a "regulation of matters of health and safety" "supports the application of the 'starting presumption' against pre-emption."

Moreover, if the provision of medical treatment to patients by an HMO were governed by ERISA fiduciary obligations, a single HMO doctor would be subject to ERISA fiduciary obligations in treating members of the HMO who are ERISA beneficiaries and differing state-law obligations in treating other members of the same HMO. Similarly, HMO physicians who treat ERISA beneficiaries would be subject to fiduciary obligations, while physicians who treat ERISA beneficiaries under a traditional fee-for-service health insurance system would be subject to the quite distinct obligations imposed by state law. Indeed, respondent's own ability to pursue her state-law malpractice claim against Dr. Pegram and against Carle Clinic as Dr. Pegram's employer—as she successfully did in the district court in this case, see Pet. App. 81a—would be open to serious question. "There is not so much as a hint * * * that Congress intended to squelch * * * state efforts" to regulate the practice of medicine when it included fiduciary duty provisions in ERISA. *Travelers*, 514 U.S. at 665.

b. The fact that an HMO does not act as an ERISA fiduciary when it provides medical treatment to patients, however, does not mean that an HMO *never* acts as an ERISA fiduciary. This Court explained in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), that a "person is a fiduciary with respect to a plan," and therefore subject to ERISA fiduciary

claims against HMO for direct negligence and vicarious liability are not subject to complete preemption doctrine under ERISA); *Rice v. Panchal*, 65 F.3d 637, 646 (7th Cir. 1995) (vicarious claims not completely preempted); *Dukes*, 57 F.3d at 356 (vicarious and direct claims not completely preempted); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994) (vicarious claims not completely preempted).

duties, 'to the extent' that he or she 'exercises any discretionary authority or discretionary control respecting management' of the plan, or 'has any discretionary authority or discretionary responsibility in the administration' of the plan." *Id.* at 498 (quoting 29 U.S.C. 1002(21)(A) (emphasis added)). In *Varity*, for example, since "obviously, not all of [the employer's] business activities involved plan management or administration," the Court had to determine whether the employer was "wearing its 'fiduciary' * * * hat" when it made the particular representations that were alleged to constitute a fiduciary breach. 516 U.S. at 498. See also *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996).

Varity, *Hughes*, and *Lockheed* establish that an entity may become an ERISA fiduciary when it performs particular functions, even if it acts as an independent entity subject to state law (such as a provider of medical services to an ERISA plan and ERISA beneficiaries) in many other of its activities. In particular, insofar as an HMO exercises "discretionary authority or discretionary responsibility in the administration of [the plan]," it takes on fiduciary status under ERISA. 29 U.S.C. 1002(21)(A). Activities that constitute "administration of [the plan]" include "determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records * * * to comply with applicable reporting requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). In the context of an HMO, the relevant administrative functions frequently performed by an HMO consist of determining eligibility under the ERISA plan, determining whether a particular treatment is covered by the plan, sending required notices and filing reports, and keeping necessary records. An HMO is an ERISA fiduciary only when and

insofar as it exercises discretionary control over those activities.⁹

4. Because an HMO frequently combines under one roof non-fiduciary functions (such as the provision of medical treatment) and fiduciary functions (such as the determination of whether particular medical services are an "intended benefit" under the ERISA plan), it sometimes can be difficult at the margins to sort out when an HMO is acting as an ERISA fiduciary and when it is not. In this case, in determining whether respondent's complaint has alleged a breach of fiduciary duty under ERISA, it is necessary to examine carefully the allegations of respondent's complaint, in order to determine whether they allege conduct by petitioners in their capacity as providers of medical services to the ERISA plan and its beneficiaries, or in their capacity as ERISA fiduciaries.

B. Petitioners Were Not Acting As Fiduciaries Under The "Treatment" Allegations Of The Complaint, Because They Allege Only Conduct That Petitioners Undertook As Providers Of Medical Services

1. The "treatment" allegations of the complaint in this case—referring to the year-end payments to physicians who minimize the use of diagnostic tests and the referral of patients to outside facilities and physicians—concern only the way in which the HMO performs the medical services it is contractually obligated to perform for the ERISA plan and its beneficiaries. They relate to the medical treatment that

⁹ It is of course possible that a particular action can constitute both administration of an ERISA plan and conduct that the State can regulate insofar as it affects outside parties. Cf. *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994), cert. denied, 516 U.S. 930 (1995) (no preemption where health care provider—not plan beneficiary—brings claim of negligent misrepresentation against ERISA plan administrator based on faulty provision of information to health care provider about coverage of the plan).

HMO physicians provide to their patients, and the way in which HMO physicians are reimbursed for providing such treatment. The court of appeals therefore erred in holding that either the HMO or its parent entities were acting in a fiduciary capacity under the "treatment" allegations of the complaint.

2. There could be no basis to argue that, although the HMO's medical treatment of patients is governed not by ERISA but by state law, the HMO's decisions regarding how to compensate its physicians who treat patients are subject to ERISA's fiduciary duty standards. See *U.S. Healthcare*, 1999 WL 728474, at *10 (HMO acted in capacity of "providing and arranging medical services" when it adopted policies that encourage physicians to implement hospital discharge and admittance policies); *Dukes*, 57 F.3d at 353, 360-361 (state-law claim that HMO was negligent in its "selection, employment, and oversight of the medical personnel who performed the actual medical treatment" relates to HMO's role as arranger of medical care, and not to HMO's ERISA administration function) (emphasis added). The permissible scope of a State's regulation of medical care clearly extends beyond the direct regulation of the quality of treatment provided by a doctor to a patient and includes as well the means of compensation by which a doctor may be reimbursed for providing care to patients.¹⁰ Cf. *De Buono*, 520 U.S. at 814 & n.10 (traditional state "regulation of matters of health and safety" includes taxation of hospitals). As noted above, if ERISA fiduciary standards govern the

¹⁰ Cf., e.g., American Medical Ass'n, Council on Ethical and Judicial Affairs, *Code of Medical Ethics* § 8.05, at 128 (1998-1999 ed.) (provisions of medical ethics code governing "contractual relationships that physicians assume when they join or affiliate with group practices or agree to provide services to the patients of an insurance plan"); *id.* § 8.051, at 129 (rules regarding "conflict of interest under capitation" schemes of "[m]anaged care organizations").

compensation arrangements for doctors who treat ERISA patients, then state laws that regulate the same subject matter would be preempted. It would be perverse to argue that state law may govern the quality of medical care provided by HMO physicians to their patients, but it cannot govern the compensation arrangements under which such physicians are reimbursed and which the State may find affect the treatment decisions made by physicians.¹¹

Indeed, if the HMO's business decisions, such as how to compensate physicians for their treatment of patients, were subject to ERISA fiduciary duty provisions, it is difficult to understand how the HMO could function as a business entity. As a business entity, HAMP has a financial incentive to arrange for medical care at the least expense to itself; that interest would conflict with its duty as a fiduciary to act solely in the interests of the participants and beneficiaries under ERISA Section 404(a)(1)(A), 29 U.S.C. 1104(a)(1)(A). In determining how to compensate its doctors, HAMP would thus be required to forgo consideration of costs, so that it could act solely in the participants' interests. *Ibid.* There is nothing in ERISA that suggests that Congress intended to place that kind of restraint on an HMO's business activities.

Furthermore, if ERISA's fiduciary duty provisions were generally applicable to an HMO's compensation of its physi-

¹¹ Many States have enacted legislation limiting incentive payments that may be made to physicians. See, e.g., Alaska Stat. § 21.86.150(i)(4) (Michie 1998); Cal. Health & Safety Code § 1348.6 (West Supp. 1999); Ga. Code Ann. § 33-20A-6 (Supp. 1999); Idaho Code § 41-3928 (1998); Kan. Stat. Ann. § 40-4605 (Supp. 1998); La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999); Md. Code Ann. Ins. § 15-113(c) (1997); Minn. Stat. § 72A.20 Subd. 33 (1999); Mo. Rev. Stat. § 354.606(9) (Supp. 1999); Mont. Code Ann. § 33-36-204(2) (1997); Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998); Nev. Rev. Stat. § 695G.260 (1998); Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998); 40 Pa. Cons. Stat. Ann. § 991.2112 (West Supp. 1999); R.I. Gen. Laws § 23-17.13-3(B)(8) (1996); Tex. Ins. Code Ann. § 3.70-3C(7)(d) (West Supp. 1999).

cians for treating ERISA beneficiaries, it would have been unnecessary for Congress to have amended ERISA specifically to address the question of incentives for the containment of medical treatment, as it has done in certain specific areas. In 1996, Congress enacted the Newborns' and Mothers' Health Protection Act, Pub. L. No. 104-204, § 603, 110 Stat. 2935, which amended ERISA to prohibit any "group health plan" or "health insurance issuer offering group health insurance coverage in connection with a group health plan" from offering incentives to an attending medical provider to provide care inconsistent with the statutorily specified two-day or four-day minimum length of hospital stay for a mother and newborn child. 29 U.S.C. 1185(b)(4) (Supp. III 1997). Significantly, a "group health plan" subject to the Act is essentially defined as an ERISA plan "providing medical care," 29 U.S.C. 1191b(a)(1) (Supp. III 1997), while a "health insurance issuer" is separately defined as "an insurance company, insurance service, or insurance organization (including a health maintenance organization * * *)," 29 U.S.C. 1191b(b)(2) (Supp. III 1997). In addition, in 1998, Congress passed the Women's Health and Cancer Rights Act, Pub. L. No. 105-277, § 902(a), 112 Stat. 2681-437 (to be codified at 29 U.S.C. 1185b(c)(2)), which similarly prohibits any "group health plan" or "health insurance issuer" from providing incentives to induce any provider to provide care in a manner inconsistent with its requirements.¹² Congress's adoption of those provisions expressly prohibiting health insurance carriers and HMOs that cover ERISA health plans from employing certain types of incentives for the containment of medical costs indicates that

¹² The requirements generally provide that a group health plan that offers coverage for a mastectomy shall also provide full coverage for breast reconstruction surgery. § 902(a), 112 Stat. 2681-436 (to be codified at 29 U.S.C. 1185b(a)).

ERISA's general fiduciary duty provisions were not intended to govern that conduct.¹³

C. The "Administration" Allegations Of The Complaint Do State A Claim That Petitioners Were Acting In A Fiduciary Capacity, But They Allege Conduct That Does Not, As A Matter Of Law, Violate Any Fiduciary Duty Under ERISA

1. In addition to alleging that financial incentives exist for physicians to minimize diagnostic tests and certain referrals in the course of providing medical care, respondent's complaint alleges that petitioners maintain a compensation scheme in which a financial incentive exists for determining claims. Although the complaint is not a model of clarity, respondent appears to allege that Carle Care physicians receive year-end payments that are funded by having physicians "determin[e] * * * which claims are covered under the Plan and to what extent," including, for example, determining "whether a course of treatment is experimental" or a "medical condition is an emergency." Pet. App. 86a. Those allegations could encompass a situation in which a Carle Care physician has discretionary authority to determine a question of coverage under the plan, as for example by

¹³ Under provisions of the Social Security Act permitting Medicare recipients to obtain benefits through enrollment in HMOs, specific restrictions apply to physician incentive payments that may be made by such HMOs. See, e.g., 42 U.S.C. 1395w-22(j)(4) (Supp. III 1997) (HMO may not make a "specific payment * * * to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the [HMO]"). See also 42 U.S.C. 1396b(m)(2)(A)(x) (Supp. III 1997) (applying same rules to Medicaid); 42 C.F.R. 422.208 (implementing Medicare regulation); 42 C.F.R. 434.70(a)(2) (implementing Medicaid regulation). A health care reform bill recently passed by the House of Representatives, see pp. 25-26, *infra*, would apply virtually the same restrictions to all group health plans and health insurers. See H.R. 2990, 106th Cong., 1st Sess. § 1133 (1999). See 145 Cong. Rec. H9523-01 (daily ed. Oct. 7, 1999).

resolving a grievance challenging a Carle Care decision not to pay for care that a beneficiary had already received at a non-Carle Care facility, on the ground that the episode had not been an emergency. See *id.* at 107a, 125a.¹⁴ Insofar as the complaint could be read to allege discretionary conduct in claims administration, it alleges conduct by petitioners in their capacity as ERISA fiduciaries.

In a long and consistent line of decisions under ERISA's preemption provision, 29 U.S.C. 1144, this Court has recognized that the processing of claims for benefits by an insurer is a plan function. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 658 (1995), for example, the Court noted that state laws that are preempted because they "relate[] to" employee benefit plans include those that "mandat[e] employee benefit structures or their administration." Similarly, the Court's decision last Term in *UNUM Life Insurance Co. v. Ward*, 119 S. Ct. 1380 (1999), that a state-law rule regarding claims processing by an insurer is saved by ERISA's insurance savings clause was necessarily based on the proposition that the state-law rule "related to" the ERISA plan. See 119 S. Ct. at 1386 (noting parties' agreement on that point). And in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987), the Court began its analysis of the question whether the causes of action there were preempted by noting that the plaintiff's common-law causes of action against an insurer for "bad faith" claims processing of the plaintiff's disability claim under an ERISA plan "relate to" the ERISA plan.

Those preemption decisions establish that, because claims processing is a plan function even when performed by in-

¹⁴ The plan document cited in the text is the subscription agreement between State Farm (the employer) and Carle Care (the HMO) that provides for enrollment of State Farm employees in Carle Care and sets the benefits to be provided.

insurance companies or other entities that are separate from the plan itself, state laws that attempt to regulate claims processing under ERISA plans are preempted (unless saved by ERISA's insurance savings clause, see *UNUM*, 119 S. Ct. at 1386-1391). Therefore, insurers that process claims under ERISA plans are performing a plan-administration function when they do so. And insofar as adjudicating claims involves the exercise of some discretion, insurers that engage in the administration of ERISA plans by performing claims processing are acting as ERISA fiduciaries when they do so.¹⁵ Because there is no reason to distinguish between traditional fee-for-service insurers and HMOs in any of these respects, it follows that HMOs may act as ERISA fiduciaries when they engage in claims administration under an ERISA plan.¹⁶

¹⁵ See, e.g., *Englehardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1352 (11th Cir. 1998); *Bailey v. Blue Cross & Blue Shield of Virginia*, 67 F.3d 53, 56 (4th Cir. 1995), cert. denied, 516 U.S. 1159 (1996); *Tregoning v. American Community Mutual Ins. Co.*, 12 F.3d 79, 82 (6th Cir. 1993), cert. denied, 511 U.S. 1082 (1994); *Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1035 (6th Cir.) (an insurance company with discretionary authority to determine claims is an ERISA fiduciary "whether the * * * company is the carrier administering claims under an insurance policy or * * * is administering claims for a fee under a self-insured plan"), cert. denied, 510 U.S. 819 (1993).

¹⁶ The courts of appeals have held that state-law claims arising from claims denials by HMOs are preempted (unless saved by the insurance savings clause). See, e.g., *Parrino v. FHP, Inc.*, 146 F.3d 699 (9th Cir.) (state-law claim based on HMO's denial of particular cancer therapy), cert. denied, 119 S. Ct. 510 (1998); *Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir. 1997) (same), cert. denied, 118 S. Ct. 1512 (1998); *Cannon v. Group Health Serv., Inc.*, 77 F.3d 1270 (10th Cir.) (state-law claim of delay by HMO and insurers in authorizing particular cancer treatment), cert. denied, 519 U.S. 816 (1996); *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298 (8th Cir. 1993) (state-law claim of delay in HMO's authorization for out-of-network surgery), cert. denied, 510 U.S. 1045 (1994).

The Department of Labor's claims-processing regulations similarly establish that the processing of claims is an essential plan function. See 29 C.F.R. 2560.503-1. Those regulations further recognize that claims processing may be done by an insurer, 29 C.F.R. 2560.503-1(c), that a plan's claims procedures may provide that claims for benefits must be filed with "an insurance company, insurance service, or other similar organization," 29 C.F.R. 2560.503-1(d)(3), and that such organization may be designated to provide notice of denial of a claim to a beneficiary, 29 C.F.R. 2560.503-1(f). Of particular significance here, the regulations provide that, with respect to plans in which benefits are provided by "an insurance company, insurance service, or other similar organization," the plan may provide that such organization "shall be the 'appropriate named fiduciary' for purposes of deciding appeals from denied claims. 29 C.F.R. 2560.503-1(g)(2). The regulations furthermore provide that claims procedures specified in the Public Health Service Act, 42 U.S.C. 300e, are sufficient to satisfy ERISA requirements "with respect to any benefits provided through membership in a qualified health maintenance organization," 29 C.F.R. 2560.503-1(j). They thus make clear that HMOs, like other health insurance entities, engage in the administration of ERISA plans when they process claims.¹⁷

¹⁷ The Department of Labor has published a new proposed claims procedure regulation. 63 Fed. Reg. 48,390 (1998). That regulation "would establish new standards for the processing of group health, disability, pension, and other employee benefit plan claims filed by participants and beneficiaries." *Ibid.* The proposed regulation was designed in large part to address the "dramatic changes" that "have occurred in the health industry" caused by the "growth of managed care delivery systems." *Id.* at 48,391. The proposed regulation therefore specifically addresses claims procedures of "group health plan services or benefits," see, e.g., *id.* at 48,405, and plans in which benefits are provided by "an insurance company, insurance service, third-party contract administrator, health maintenance organization, or similar entity," *id.* at 48,406 (emphasis added).

2. For the foregoing reasons, we disagree with Judge Easterbrook's suggestion, dissenting from denial of rehearing en banc, that "the Carle Care HMO system [is] the benefit promised by the ERISA plan," not the "particular medical services" offered by the HMO. Pet. App. 55a. That suggestion would place HMO coverage in an entirely different regulatory category from other forms of health coverage, such as traditional health insurance. This Court's decisions in *Pilot Life* and *UNUM* establish that the benefit offered in a traditional insured ERISA plan is not the insurance policy, but the specific benefits offered under the insurance policy; because the processing of claims for particular benefits is a subject addressed by ERISA, the state laws governing claims processing in those cases "related to" ERISA plans. Yet, if Judge Easterbrook's rule were adopted, the rule would be precisely the opposite in the case of an HMO. There is no reason why the scope of ERISA's coverage—and, correspondingly, of state law's application—should vary so widely depending on whether an ERISA plan offers traditional health insurance coverage or HMO coverage instead.

Moreover, Judge Easterbrook's proposal would have serious consequences for the operation of HMOs. For example, this Court's decision in *Pilot Life* was based on the premise that a state-law claim for "bad faith" processing of claims by an insurer under an ERISA plan is preempted, because such a claim "relates to" the ERISA plan. But if the "intended benefit," see p. 10, *supra*, of the ERISA plan is simply membership in an HMO, then the only "claims processing" that would occur under ERISA with respect to the HMO is the processing of claims that an individual is entitled to enroll in the HMO; claims for particular medical benefits would not be claims for benefits under the ERISA plan, but would rather be internal matters between the HMO and its members. It follows that state laws governing the pro-

cessing of claims for particular medical benefits would govern that area entirely, including state law provisions permitting compensatory and punitive damages and other remedies not permitted by ERISA.

Congress currently has before it a variety of proposals that would eliminate ERISA preemption of state-law causes of action for damages (including, in some cases, punitive damages) by ERISA beneficiaries against HMOs and other group health plans. For example, H.R. 2990, a bill recently passed by the House of Representatives, see 146 Cong. Rec. H9523-01 (daily ed. Oct. 7, 1999), would eliminate preemption of such damages actions "in connection with the provision of insurance, administrative services, or medical services by [a] person to or for a group health plan * * * or * * * that arises out of the arrangement by [a] person for the provision of such insurance, administrative services, or medical services by other persons." H.R. 2990, 106th Cong., 1st Sess. § 1302(a) (1999).¹⁸ It is a premise of the House bill that ERISA currently operates to restrict such state-law causes of action, because they would regulate benefits decisions under ERISA. Under Judge Easterbrook's reading, however, any such legislative change would be unnecessary, since decisions by HMOs regarding whether particular medical benefits are covered would not be decisions concerning the benefits due under an ERISA plan and would therefore not be subject to preemption under ERISA. Any such far-reaching change should be enacted by Congress, not by

¹⁸ A number of bills addressing HMOs and their relationship to ERISA are currently in the forefront of congressional consideration. Quality Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong., 1st Sess., 145 Cong. Rec. H9523-01 (daily ed. Oct. 7, 1999); Patients' Bill of Rights Plus Act, S. 1344, 106th Cong., 1st Sess., 145 Cong. Rec. S8623 (daily ed. July 15, 1999) (bill passed as amended); see H.R. Res. 348, 106th Cong., 1st Sess., 145 Cong. Rec. H11341 (daily ed. Nov. 2, 1999) (House disagrees with Senate amendment to H.R. 2990 and agrees to conference).

judicial fashioning of an artificially narrow definition—apparently applicable only to HMOs and not to traditional insurers—of the “intended benefits” offered under an ERISA plan.

3. Because processing of claims for medical benefits—whether undertaken by the plan sponsor, a traditional fee-for-service insurer, or an HMO—is a function of ERISA plan administration, any individual or entity that exercises discretion in the processing of such claims is an ERISA fiduciary. And to the extent the complaint in this case alleges that Carle Care physicians make discretionary decisions in deciding claims, it has alleged conduct that is fiduciary in nature. Cf. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331-1332 (5th Cir.) (decision that a particular benefit is not covered by the plan involves plan administration, even though there is a medical component to the decision), cert. denied, 506 U.S. 1033 (1992); see generally 29 C.F.R. 2509.75-8 (determining benefit eligibility will involve fiduciary status if discretion is exercised, i.e., if it involves more than “ministerial functions * * * within a framework of policies, interpretations, rules, practices and procedures made by other persons”). Indeed, petitioners appear to have acknowledged that fiduciary status and a duty of loyalty apply in such a context, stating that in contrast to the HMO’s cost-containment and other business decisions, the HMO “must make coverage and eligibility decisions under the plan with an ‘eye single’ to the interests of the patient/beneficiaries.” Pet. 28. Similarly, in their reply brief at the certiorari stage, petitioners stated that they “freely acknowledge that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, e.g., when they provide information to participants as required under ERISA and when they make decisions about who is eligible for plan benefits.” Pet. Reply Br. 7 (emphasis added).

The “administrative” allegations in the complaint, if liberally construed, could be read to allege conduct by petitioners in their fiduciary status. Those allegations state that petitioners “administer[] disputed and non-routine health insurance claims.” Pet. App. 86a. Specifically, the complaint alleges that petitioners “determin[e] * * * which claims are covered under the Plan” and several other issues that are determinative of coverage, such as “what the applicable standard of care is,” “whether a course of treatment is experimental,” “whether a course of treatment is reasonable and customary,” and “whether a medical condition is an emergency.” *Ibid.* Because those specific allegations are phrased in terms of “administering” the plan, rather than providing medical care, we do not read them to refer to a treating physician’s determination of how to treat a patient, whether a course of treatment is sufficiently proven to be safe, or whether an emergency exists that calls for the use of particular medical emergency protocols. Rather, we read those allegations to refer to the claims administration process within the HMO, which is triggered when individuals (or, perhaps, treating physicians) seek determination of whether particular medical services are covered by the plan. Insofar as the complaint alleges that petitioners act in the role of claims decisionmakers, the complaint therefore alleges that they act as ERISA fiduciaries. See also J.A. 102 (Summary Plan Description of State Farm Group Medical Health Plan) (“Although State Farm * * * is the Plan Administrator and Plan Sponsor * * *, any and all benefit determinations will be made by each individual HMO.”).

4. Although the complaint does allege that petitioners act as ERISA fiduciaries insofar as they make determinations concerning benefits under the ERISA plan, the question remains whether the complaint adequately alleges the existence of an incentive scheme that would constitute a violation of the duty of loyalty in the context of exercising

that particular fiduciary responsibility, i.e., of deciding benefit claims.

In our view, the fact that a denial of coverage by a Carle Care physician represents a cost saving for the HMO and that this same physician has some ownership interest in the HMO would not in itself establish a fiduciary breach. Under typical arrangements for employee benefit plans, such as an insured health plan where the insurance company has discretionary authority to decide claims, or a plan under which a company employee has such authority and the employer pays claims out of its own assets, there is some measure of divided loyalty on the part of a claims decisionmaker. ERISA, however, tolerates the level of divided loyalty that is intrinsic to those common arrangements, so that ERISA plans will be created and insurance companies and others will find it practical to work for them. Cf. 29 U.S.C. 1108(c) (party-in-interest may serve as fiduciary).¹⁹ The mere existence of such a potential conflict is not therefore a basis for a claim of breach of fiduciary duty.

On the other hand, a claim that an incentive scheme constituted a breach of fiduciary duty would be established if the scheme provided incentives of such a nature that the individual deciding claims for benefits would be unable to set aside personal interest and make the benefits determination based on the terms of the plan. Cf. *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.) (trustees should "avoid placing themselves in a position where their acts as officers or directors of the corporation will prevent their functioning

¹⁹ *Firestone Tire & Rubber* established that any such arrangement should be "weighed as a factor in determining whether there is an abuse of discretion" in a claim for denial of benefits under ERISA Section 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B). 489 U.S. at 115 (internal quotation marks omitted). The courts of appeals have varied in their approach to factoring in such systemic divided loyalties. See *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998).

with the complete loyalty to participants demanded of them as trustees"), cert. denied, 459 U.S. 1069 (1982). For example, a compensation scheme that provided direct financial incentives to plan fiduciaries for making adverse rulings on benefits claims—e.g., a (highly unlikely) scheme providing fiduciaries with a fee for each claim they deny—would run afoul of the duty of loyalty.

5. Read literally, the "administrative" allegations in the complaint merely allege that petitioners "seek to fund their supplemental medical expense payments * * * by administering disputed and non-routine health insurance claims" and making the determinations necessary to such administration. Pet. App. 86a. That is merely an allegation that petitioners make a profit by administering the ERISA plan, and it certainly does not state a claim of breach of fiduciary duty. Even if it were construed, however, to allege as well that petitioners employed some form of compensation scheme in which those processing claims for the HMO shared in the HMO's general profits, it would not allege a breach of fiduciary duty under ERISA, for the reasons given above.

Nothing in the complaint itself suggests that respondent was intending to plead that petitioners employed the kind of unusual incentive scheme, described above, in which those who decide disputed claims would be paid on the basis of how many claims they deny or would otherwise be paid in a way that violates ERISA's standards of fiduciary duty. Indeed, the court of appeals read the complaint to allege only that physicians at the HMO who participate in claims processing are provided with a bonus payment based on the HMO's overall profits. See, e.g., Pet. App. 19a ("Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (i.e., the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bo-

nuses.") (emphasis omitted); *id.* at 21a (complaint alleges that petitioners "control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals") (emphasis omitted). Because the "administrative" allegations of the complaint therefore do not allege a breach of fiduciary duty under ERISA, the judgment of the court of appeals should be reversed.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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Supreme Court, U. S.
F I L E D
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No. 98-1949

IN THE
SUPREME COURT OF THE UNITED STATES

OFFICE OF THE CLERK

**LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,**
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari To The
United States Court of Appeals
For the Seventh Circuit

**BRIEF *AMICI CURIAE* OF AARP, NATIONAL
EMPLOYMENT LAWYERS ASSOCIATION AND
NATIONAL SENIOR CITIZENS LAW CENTER
IN SUPPORT OF NEITHER PARTY**

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3188

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QUESTIONS PRESENTED ^{1/}

1. Is federal court jurisdiction lacking because Ms. Herdrich's original state law claims could not be brought under § 502(a) of ERISA's civil enforcement provisions inasmuch as Petitioners were not acting in any ERISA capacity?
2. If this Court has jurisdiction and finds that Ms. Herdrich's allegations present cognizable claims under ERISA's fiduciary rules, are ERISA fiduciaries liable to employee benefit plans, under ERISA § 502(a)(2), for restitution of bonuses and profits gained by committing fiduciary breaches?

^{1/} Although *amici* will not focus on the ostensibly narrow question presented in the Petition for Writ of Certiorari, the issues of jurisdiction, preemption and remedies are subsumed within the original question presented. In addition, they were raised, briefed, and decided below, and we believe that the district court rulings on these issues were erroneous. See Supreme Court Rule 14.1(a) ("[t]he statement of any question presented is deemed to comprise every subsidiary question fairly included within"); Supreme Court Rule 24.1(a) (in its discretion, the Court "may consider a plain error not among the questions presented but evident from the record and otherwise within its jurisdiction to decide").

TABLE OF CONTENTS

	<u>Page</u>
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF <i>AMICI CURIAE</i>	1
STATEMENT OF THE CASE	3
SUMMARY OF ARGUMENT	6
ARGUMENT	7
I. BECAUSE RESPONDENT'S STATE LAW CLAIMS CANNOT BE BROUGHT UNDER ERISA'S CIVIL ENFORCEMENT PROVISIONS WHERE PETITIONERS ARE MERELY ACTING AS HEALTH CARE SERVICE PROVIDERS TO AN ERISA PLAN, THERE IS NO FEDERAL COURT JURISDICTION	7
A. Proper Removal of a State Law Claim Requires That It Can Be Brought under Section 502(a) of ERISA	8
B. HMOs Are Not Subject to Suit under Section 502(a) of ERISA Where They Act as Providers of Health Care Services and Not as an ERISA Plan or in Any Other ERISA Capacity	9
C. Where HMOs Act as Medical Entrepreneurs Rather than in an ERISA Capacity, There Is No ERISA-Governed Relationship and State Laws Regulating Them as Such Are Not Preempted By Section 514(a) of ERISA	14

II. ERISA FIDUCIARIES ARE LIABLE TO THE PLAN FOR RESTITUTION OF BONUSES AND PROFITS WHICH THEY GAIN BY THEIR COMMISSION OF FIDUCIARY BREACHES ...	19
CONCLUSION	23

TABLE OF AUTHORITIES

CASES

<i>Airparts Co. v. Custom Benefit Services</i> , 28 F.3d 1062 (10th Cir. 1994)	17
<i>Amalgamated Clothing & Textile Workers v. Murdock</i> , 861 F.2d 1406 (9th Cir. 1988)	20, 21, 22
<i>American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.</i> , 973 F. Supp. 60 (D. Mass. 1997)	11, 12
<i>Anderson v. Humana, Inc.</i> , 24 F.3d 889 (7th Cir. 1994)	18
<i>Arizona State Carpenters Pension Trust Fund v. Citibank</i> , 125 F.3d 715 (9th Cir. 1997)	17, 18
<i>Bast v. Prudential Insurance Co.</i> , 150 F.3d 1003 (9th Cir. 1998), <i>cert. denied</i> , 120 S. Ct. 170 (1999) ...	20
<i>Blue Cross of California v. Anesthesia Care Associates</i> , 187 F.3d 1045 (9th Cir. 1999)	10, 12, 13
<i>Boggs v. Boggs</i> , 520 U.S. 833 (1997)	3
<i>California Division of Labor Standards Enforcement v. Dillingham Construction</i> , 519 U.S. 316 (1997)	3, 15, 15, 18
<i>Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.</i> , 472 U.S. 559 (1986)	20
<i>Cippolone v. Liggett Group</i> , 505 U.S. 504 (1992)	18
<i>Coyne & Delany Co. v. Selman</i> , 98 F.3d 1457 (4th Cir. 1996)	10, 17, 18

<i>Custer v. Sweeney</i> , 89 F.3d 1156 (4th Cir. 1996)	17, 18
<i>De Buono v. NYSA-ILA Med. & Clinical Services Fund</i> , 520 U.S. 806 (1997)	3, 7, 15, 16
<i>Donovan v. Bierwith</i> , 680 F.2d 263 (2d Cir. 1982)	21
<i>Donovan v. Dillingham</i> , 688 F.2d 1367 (11th Cir. 1982)	12
<i>Dukes v. U.S. Healthcare</i> , 57 F.3d 350 (3rd Cir. 1995), <i>cert. denied</i> , 116 S. Ct. 1876 (1996)	13, 16
<i>Eaves v. Penn</i> , 587 F.2d 453 (10th Cir. 1978)	21
<i>Franchise Tax Board Of California v. Construction Laborers Vacation Trust for Southern California</i> , 463 U.S. 1 (1983)	9
<i>Geissal v. Moore Medical Corp.</i> , 118 S. Ct. 1869 (1998)	3
<i>Herdrich v. Pegram</i> , 154 F.3d 362 (7th Cir. 1998) ..	<i>passim</i>
<i>Hospice of Metropolitan Denver, Inc. v. Group Health Insurance of Okla., Inc.</i> , 944 F.2d 752 (10th Cir. 1991)	17
<i>Ingersoll-Rand v. McClendon</i> , 498 U.S. 133 (1990)	8
<i>In re U.S. Healthcare</i> , ___ F.3d ___, 1999 WL 728474 (3rd Cir. 1999)	9, 10, 13
<i>Inter-Modal Rail Employees Association v. Atchison, Topeka & Santa Fe Railway Co.</i> , 520 U.S. 510 (1997)	3
<i>John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank</i> , 510 U.S. 86 (1993)	17
<i>LeBlanc v. Cahill</i> , 153 F.3d 134 (4th Cir. 1998)	17

<i>Leigh v. Engle</i> , 727 F.2d 113 (7th Cir. 1984)	21
<i>Louisville & Nashville R. Co. v. Mottley</i> , 211 U.S. 149 (1908)	7
<i>Lupo v. Human Affairs International Inc.</i> , 28 F.3d 269 (2d Cir. 1994)	16
<i>Mackey v. Lanier Collections Agency & Service</i> , 486 U.S. 825 (1988)	18
<i>Massachusetts Mutual Life Insurance Co. v. Russell</i> , 473 U.S. 134 (1985)	14, 20
<i>Memorial Hospital System v. Northbrook Life Insurance Co.</i> , 904 F.2d 236 (5th Cir. 1990)	17
<i>Mertens v. Hewitt Associates</i> , 508 U.S. 248 (1993)	20, 21
<i>Metropolitan Life Insurance Co. v. Taylor</i> , 481 U.S. 58 (1987)	8, 9, 14
<i>Morstein v. National Insurance Services, Inc.</i> , 93 F.3d 715 (11th Cir. 1996)	19
<i>New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.</i> , 514 U.S. 645 (1995)	14, 18
<i>Pacificare of Oklahoma, Inc. v. Burrage</i> , 59 F.3d 151 (10th Cir. 1995)	16
<i>Pappas v. Asbel</i> , 724 A.2d 889 (Pa. Supreme Ct. 1998), <i>petition for cert. pending, sub. nom.</i> <i>United States Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Co., et al.</i> , 67 U.S.L.W. 3717 (May 13, 1999)	16
<i>Perkins v. Time Insurance Co.</i> , 898 F.2d 470 (5th Cir. 1990)	19

<i>Rice v. Panchal</i> , 65 F.3d 637 (7th Cir. 1995)	8, 14, 16
<i>Shaw v. Delta Air Lines</i> , 463 U.S. 85 (1983)	15
<i>Strom v. Goldman, Sachs & Co.</i> , 1999 WL 639844 (No. 98-7090) (2d Cir. Aug. 24, 1999)	20
<i>Sumner v. Mata</i> , 449 U.S. 539 (1981)	7
<i>Toumajian v. Frailey</i> , 135 F.3d 648 (9th Cir. 1998) ...	8, 14
<i>UNUM v. Ward</i> , 119 S. Ct. 334 (1999)	3
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	3
<i>Waller v. Blue Cross of California</i> , 32 F.3d 1337 (9th Cir. 1994)	22
<i>Washington Physicians Service Associate v. Gregoire</i> , 147 F.3d 1039 (9th Cir. 1998)	11
<i>Wilson v. Zoellner</i> , 114 F.3d 713 (8th Cir. 1997)	19
<i>Woodworker's Supply, Inc. v. Principal Mutual Life Insurance Company</i> , 170 F.3d 985 (10th Cir. 1999) ...	19

STATUTES AND RULES

ERISA, 29 U.S.C. § 1001 <i>et seq.</i>	3, 5
§ 3, 29 U.S.C. § 1002(21)	13
§ 409, 29 U.S.C. § 1109	20, 23
§ 502, 29 U.S.C. § 1132	5
§ 502(a), 29 U.S.C. § 1132(a)	<i>passim</i>
§ 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)	10
§ 502(a)(2), 29 U.S.C. § 1132(a)(2)	i, 7, 20, 21
§ 502(a)(3), 29 U.S.C. § 1132(a)(3)	21
§ 502(e), 29 U.S.C. § 1132(e)	8
§ 502(e)(1), 29 U.S.C. § 1132(e)(1)	8
§ 514, 29 U.S.C. § 1144	5, 6, 11
§ 514(a), 29 U.S.C. § 1144(a)	<i>passim</i>

Supreme Court Rule 14.1(a)	i
Supreme Court Rule 24.1(a)	i
Supreme Court Rule 37.3	3

MISCELLANEOUS

G. T. Bogert, <i>Trusts, Creation of Constructive Trusts</i> (6th ed. 1987)	
§ 86	21
§ 87	21
Karen A. Jordan, <i>Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption</i> , 13 YALE J. REG. 255 (1996)	12
RESTATEMENT (FIRST) OF RESTITUTION (1936)	
§ 138(1)	21
§ 160	21
§ 197	21, 22
RESTATEMENT (THIRD) OF TRUSTS (1990)	
§ 205(a)	21

No. 98-1949

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1998

**LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,**
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

**ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

**BRIEF AMICI CURIAE OF AARP, NATIONAL
EMPLOYMENT LAWYERS ASSOCIATION AND
NATIONAL SENIOR CITIZENS LAW CENTER
IN SUPPORT OF NEITHER PARTY**

INTEREST OF AMICI CURIAE ^{2/}

Three national organizations join in this brief which focuses on two issues -- first, whether the federal court lacked jurisdiction over Ms. Herdrich's original state law claims because those claims cannot be brought pursuant to the Employees Retirement Income Security Act's (ERISA) civil enforcement provisions, and second, if there is federal court jurisdiction, whether ERISA fiduciaries are liable to employee benefit plans for restitution of bonuses and profits gained by

^{2/} No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

committing fiduciary breaches. As the following descriptions of these organizations demonstrate, they have a significant interest in the outcome of this case.

AARP is a nonprofit membership organization of more than 33 million Americans age 50 or older, dedicated to addressing the needs and interests of older people. Approximately one-third of AARP's members are working and rely on employer-funded health benefits for their health coverage. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling its costs without compromising quality.

The National Senior Citizens Law Center (NSCLC) is a nonprofit organization that advocates on behalf of elderly poor people. Since its formation in 1972, NSCLC has engaged in judicial, legislative and administrative advocacy, technical assistance, and training in many areas of elder law, including health care. NSCLC has brought numerous law suits on behalf of ERISA-covered beneficiaries to protect their rights under that federal statute and its implementing regulations.

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of over 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of lawyers who primarily represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.

Each of the *amici* organizations thus advocates on behalf of individuals throughout the country to protect the rights of

individuals who are participants in private, employer-sponsored employee benefit plans covered by ERISA, 29 U.S.C. § 1001 *et seq.* For instance, AARP and NELA have filed numerous briefs *amicus curiae*, both jointly and singly, on the interpretation of ERISA's preemption clause, including in *UNUM v. Ward*, 119 S. Ct. 334 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), as well as in other types of ERISA cases. See, e.g., *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998) (COBRA rights); *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997) (application of ERISA § 510 to welfare plans); *Varity Corp. v. Howe*, 516 U.S. 489 (1996) (participant rights under ERISA § 502(a)(3)).

The decision in this case will have a direct and vital bearing on the quality of health care that older working Americans receive. In light of the significance of the issues presented by this case, *amici curiae* respectfully submit this brief.^{3/}

STATEMENT OF THE CASE

Dr. Lori Pegram, a Carle Clinic Association physician, examined Cynthia Herdrich and determined that she had an inflamed mass in her abdomen. Carle Clinic, a medical corporation owned by its physician-shareholders, generally required that its HMO patients receive diagnostic tests only from Carle-owned facilities. Petition for Writ of Certiorari (Pet.) 3 & 4, n.1. While Ms. Herdrich waited eight days to obtain an ultrasound at a Carle Clinic facility, her appendix ruptured. *Herdrich v. Pegram*, 154 F.3d 362, 374 (7th Cir. 1998).

Ms. Herdrich sued Dr. Pegram and Carle Clinic in state court alleging two counts of medical malpractice and later added two other counts against Carle Clinic and Health Alliance Medical

^{3/} The written consents of the parties have been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

Plans (HAMP). Pet. 4. HAMP is a health maintenance organization (the HMO), a prepaid insurance plan which contracted with State Farm Insurance Company to provide Ms. Herdrich's health care through Carle Clinic. HAMP's sole shareholder is Carle Clinic. Pet. 3. Count III alleged that Carle Clinic violated the Illinois Consumer Fraud Act by failing to reveal to Ms. Herdrich that the Carle Clinic physicians hired by HAMP in fact owned HAMP and by failing to inform her that Carle doctors earned bonuses based upon the amount of profits generated by not making emergency or consultation referrals, by not ordering diagnostic tests, and by requiring patients to use only Carle-owned facilities. Respondents' Brief in Opposition, Appendix (Res. App.) 25a. Count IV alleged HAMP breached its state law contractual duties of good faith and fair dealing by limiting tests and referrals to the detriment of its patients in order to increase its profits. *Herdrich*, 154 F.3d at 366, n. 2.

Petitioners removed the case to federal court claiming that Counts III and IV were preempted by § 514(a) of ERISA (29 U.S.C. § 1144(a)) because Ms. Herdrich's health care was paid for by her husband's employer, State Farm Insurance Company. Res. App. 24a. Respondent moved for remand, arguing the claims were not preempted. Pet. App. 66a. The court ruled that Count IV was preempted on the basis that it was related to an ERISA plan, left open the question of Count III, and denied remand. *Id.* at 68a; Res. App. 8a. Subsequently, ruling on Petitioners' motion for summary judgment on Counts III and IV, the district court also held Count III was preempted under the Supreme Court's "broad interpretation of the 'relate[s] to' requirement." Pet. App. 77a. The court held because ERISA "comprehensively regulates the necessary disclosures," Count III "relate[d] to an employee benefit plan, and as such is preempted" under § 514. *Id.* at 77a and 79a. The court then ordered Ms. Herdrich to amend Count III to allege a cause of action under ERISA or face dismissal with prejudice. *Id.* at 79a-80a. The court stated that "[h]aving found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be [sic] provide a cause of action for Plaintiff. The availability of a federal remedy does

not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA." *Id.* at 79a.^{4/}

Following that Order, Ms. Herdrich amended Count III to allege that Carle Clinic, HAMP and Carle Health Insurance Management Co. (CHIMCO), a management entity solely owned by Carle Clinic, breached fiduciary duties under ERISA. Pet. App. 83a-87a; Pet. 3. Ms. Herdrich asked that the court order Carle Clinic to reimburse the Plan for the "supplemental medical expense payments received from HAMP and CHIMCO," and for "other equitable relief." Pet. App. 87a. Petitioners moved to dismiss Amended Count III for failure to state a claim under ERISA. *Herdrich*, 154 F.3d at 367. The district court granted that motion on the ground that "plaintiff fails to identify how any of the defendants is involved as a fiduciary to the plan." Pet. App. 63a.^{5/}

On appeal, the Seventh Circuit ruled Amended Count III was sufficient to withstand a motion to dismiss. Ms. Herdrich's allegations that Petitioners had the exclusive right to decide all disputed and non-routine claims enabled the court to "reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims." 154 F.3d at 370. The Seventh Circuit also held that

^{4/} Whether or not the district court was correct in its assertion as to preemption, it was incorrect with regard to the question of whether removal was proper. As discussed in the text *infra*, the propriety of removal depends on the existence of an ERISA claim under 29 U.S.C. § 1132, not on preemption under 29 U.S.C. § 1144.

^{5/} In arguing for preemption, Petitioners stated HAMP "was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. § 1001 *et seq.*)." Res. App. 24a. The district court noted that throughout the litigation, Petitioners represented that they were all fiduciaries of the ERISA plan, but the district court did not expressly make such a finding. Pet. App. 69a. On appeal, Petitioners did not argue that they were not fiduciaries, but instead, argued the appeal was not timely and that Herdrich's request for damages was inappropriate because ERISA beneficiaries "may not recover 'anything other than the benefits provided expressly in the plan.'" *Herdrich*, 154 F.3d at 367.

"plan beneficiaries have standing to bring an action on behalf of the plan to recoup monies in violation of ERISA," and that Ms. Herdrich "alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants' actions." *Id.* at 380. The appeals court explicitly held that the mere existence of financial incentives to limit care does not automatically give rise to a breach of fiduciary duty, but that "incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)." *Id.* at 373. The case was remanded to give Ms. Herdrich the opportunity to prove all the elements of her claims at trial. *Id.* at 380.

SUMMARY OF ARGUMENT

Because Ms. Herdrich sued Carle Clinic physicians and the HMO they own for actions they took in running their health care business, rather than for actions they took as fiduciaries administering or managing an ERISA plan, the district court erred when it ruled that the case was properly removed because ERISA preempted her state law claims for violation of the Illinois Consumer Fraud Act and breach of the duty of good faith and fair dealing. These claims cannot be brought under ERISA's civil enforcement provisions, which are set forth in ERISA § 502, 29 U.S.C. § 1132(a). Therefore, ERISA does not provide federal court jurisdiction over her state law claims, and removal of these claims from state court was improper.

Although § 514 of ERISA is not directly implicated in this case, this Court's recent analysis of that provision demonstrates that the state law claims at issue here are not the types of claims which Congress intended to preempt under ERISA; ERISA was designed to regulate employee benefit plans, not the services which those plans purchase. The district court erred in forcing the plaintiff to replead her claims under ERISA, rather than remanding the state claims back to state court.

Amici ask the Court to address the question of whether the net of ERISA preemption was cast too widely in this case before reaching the issue of whether fiduciary liability under the statute has been stretched beyond Congress' intent as asserted in the Petition for Writ of Certiorari. Pet. 11. However, if the Court finds that original state law claims were displaced by ERISA's civil enforcement provisions and thus, federal court jurisdiction exists, and further, finds that the plaintiff has stated a cognizable claim under ERISA's fiduciary duty rules, the Court should find that disgorgement of profits to the plan is appropriate relief under ERISA § 502(a)(2).

ARGUMENT

I. BECAUSE RESPONDENT'S STATE LAW CLAIMS CANNOT BE BROUGHT UNDER ERISA'S CIVIL ENFORCEMENT PROVISIONS WHERE PETITIONERS ARE MERELY ACTING AS HEALTH CARE SERVICE PROVIDERS TO AN ERISA PLAN, THERE IS NO FEDERAL COURT JURISDICTION.

In its decisions, the district court concluded that the breadth of this Court's interpretation of ERISA's preemption clause warranted a conclusion that Ms. Herdrich's state law claims were preempted by § 514(a) (29 U.S.C. § 1144(a)). Pet. App. 77a and 79a (Count III); Res. App. 8a (Count IV). The court never held that it had jurisdiction under the civil enforcement provisions in ERISA § 502(a) (29 U.S.C. § 1132 (a)). Instead, the court assumed jurisdiction under § 514(a) and required Ms. Herdrich to replead her complaint under ERISA. Pet. App. 76a-79a. The court was wrong in its assumption of jurisdiction, an issue which was not reviewed by the Seventh Circuit.⁶⁷

⁶⁷ This Court should address the question of subject matter jurisdiction, whether or not it has been preserved by the parties. *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 152 (1908). In *Sumner v. Mata*, 449 U.S. 539, 548, n. 2 (1981), this Court decided the underlying jurisdictional issue where, as in this case, jurisdiction was raised as an issue before the district court but abandoned before the court of appeals. See *De Buono v. NYSA-*

A. Proper Removal of a State Law Claim Requires That It Can Be Brought under Section 502(a) of ERISA.

Federal courts have concurrent jurisdiction with state courts over individual claims for benefits under the terms of an employee benefit plan, but federal courts alone have exclusive jurisdiction over all other claims authorized by ERISA § 502(a). ERISA § 502(e), 29 U.S.C. § 1132(e). Thus, in order to remove a state law claim, that claim must be displaced by ERISA's civil enforcement provisions under § 502(a). See *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990) (state wrongful discharge action completely displaced by ERISA § 510; therefore claim properly removed). If the state law claim cannot be brought under ERISA's civil enforcement provisions, then there is no federal question jurisdiction under ERISA and removal is improper. ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1). See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987) ("It is long-settled law that a cause of action arises under federal law only when the plaintiff's well pleaded complaint raise issues of federal law"); *Toumajian v. Frailey*, 135 F.3d 648 (9th Cir. 1998) (no removal unless claim is encompassed within ERISA's civil enforcement scheme); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (same).

Because, as discussed below, Ms. Herdrich's claims could not be brought under ERISA § 502(a), the district court did not have jurisdiction of this case and her claims were improperly removed. See *Metropolitan Life Ins. Co. v. Taylor*, *supra*; *Franchise Tax Bd. Of California v. Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 9-12 (1983) (federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint).

ILA Medical and Clinical Services Fund, 520 U.S. 806, 820 (1997) (Scalia, dissenting) (jurisdiction must be decided before merits are reached).

B. HMOs Are Not Subject to Suit under Section 502(a) of ERISA Where They Act as Providers of Health Care Services and Not as an ERISA Plan or in Any Other ERISA Capacity.

When an employer establishes an employee health benefits plan, there are a variety of ways it can structure the provision of those benefits to employees. Employers may implement a plan through the purchase of insurance, self-funding, and/or the use of service providers such as managed health care plans like HMOs or preferred provider organizations (PPOs). HMOs that contract with employers to provide health care services to employees through an ERISA plan can simultaneously play different roles in relation to that ERISA plan.

Many courts have recognized the different hats HMOs wear when providing managed health care for employee beneficiaries of ERISA plans. For example, in *In re U.S. Healthcare*, ___ F.3d ___, 1999 WL 728474 (3d Cir. 1999), the Third Circuit distinguished between the HMO as administrator of an ERISA plan and the HMO as provider of health care. The Third Circuit stated:

As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes* [57 F.3d 350 (3d Cir. 1995)], claims that fall within the essence of the administrator's activities in this regard fall within section 502(a)(1)(B) and are completely preempted.

In contrast . . . when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or through contracts with hospitals, doctors, or nurses. In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care.

Id. at *8 (citations omitted). In reviewing plaintiffs' claims in that case, the Third Circuit found that the HMO's policies and actions were taken in its capacity as a provider of medical care, not as a determiner of benefit eligibility. Accordingly, the HMO's presumptive policy of discharging newborns within twenty four hours of birth, as well as its policy of discouraging physicians from readmitting newborn infants, were policies adopted in providing and arranging medical services, policies "that adversely influenced the medical judgment of its participating physicians." *Id.* at *10. The Third Circuit also held that the allegation that the HMO was negligent in its selection, supervision and training of the employee-doctor was clearly one involving quality of care. ERISA did not preempt those claims because they "do not involve an attempt to recover benefits due, enforce rights, or clarify future benefits under a plan, but rather seek recovery under the quality standard found in the otherwise applicable [state] law." *Id.* at *10 (quotation and citation omitted).

Similarly, *Blue Cross of California v. Anesthesia Care Associates*, 187 F.3d 1045 (9th Cir. 1999), demonstrates the distinction between an HMO acting as a fiduciary in handling benefit claims and acting as an entrepreneur in its relationships as medical care contractors. At issue were whether claims for fees under a contract between health plans and medical providers were preempted by ERISA because they fell within the civil enforcement provisions of § 502(a) or related to a plan under ERISA's express preemption clause of § 514(a). The Ninth Circuit rejected the HMO's argument that this fee dispute was really a benefit claim under § 502(a)(1)(B). Instead, the court stated that "[t]he dispute here is not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment which depends on the terms of the provider agreements." *Blue Cross*, 187 F.3d at 1051. Moreover, merely because an ERISA plan is consulted in the course of litigating a state law claim does not cause the state law claim to be extinguished by ERISA. *Id.*; accord, *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1472 (4th Cir. 1996). The court in *Blue Cross* also found that these claims did not relate to ERISA plans under § 514 because "there is no contention here that the

economic impact will be so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage." *Blue Cross*, 187 F.3d at 1053. Nor did the providers' state law claims implicate any ERISA-governed relationship. Instead, the claims concerned contractual promises made by the HMO to its participating physicians. *Id.* at 1054. This decision clearly underscores the variety of functions that an HMO may perform and shows the necessity of reviewing the HMO's status in relation to the claim at issue on a case by case basis.

In a somewhat different context, *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), further illustrates the difference between an ERISA plan or plan fiduciary and a service provider to that plan. There, the Ninth Circuit found that a state's alternative provider statute did not have a significant connection with an ERISA plan because the statute required action solely by health providers; it did not require an ERISA plan to do anything. The statute only regulated and mandated benefits provided by insurers. The "mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it 'relates to' an ERISA plan." *Id.* at 1045.

American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60 (D. Mass. 1997), shows the necessity of looking beyond the bare conclusory allegations that an HMO is an ERISA-governed entity. *American Drug Stores* brought suit to gain admission to the restricted pharmacy network through which Harvard Pilgrim, an HMO, contracted to supply its patient-customers. Massachusetts' "any willing provider" statute required that Harvard Pilgrim, the carrier, permit any pharmacy to join its network as long as the non-network pharmacy agreed to the same terms as network pharmacies, but the statute did not dictate the terms of such agreements. In a thoughtful analysis of this Court's more recent preemption cases, the court held that Massachusetts' "any willing provider" statute was not preempted because "the organization and offering of restricted networks is part of the carrier's own administration rather than its administration of ERISA plans." *Id.* at 68. In reaching its decision, the court enumerated the "limited range of administrative functions which are part of

operating an employee benefit plan" – "eligibility determinations, benefit calculations, disbursements, fund monitoring or record keeping." *Id.* at 67. Moreover, the court concluded that even if a carrier performs some activities that amount to plan administration, not "everything carriers do for ERISA plans is entitled to the same protection."²¹ *Id.* citing Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. REG. 255, 303 (1996) (arguing for recognition of the distinction between ERISA functions and business functions).

As the above cases illustrate and Petitioners concede, Carle Clinic and HAMP serve multiple roles in their relationship to patients, ERISA plans, and third party payors. Pet. 19. While Petitioners may function as ERISA fiduciaries in some of their dealings with Respondent (*e.g.*, if they decide whether a procedure is covered by the plan), in order to determine whether the state law claims at issue must be brought under ERISA's civil enforcement provisions, the Court must look at the state law claim itself and the role of the Petitioners in relation to that claim. *Blue Cross*, 187 F.3d at 1051; *American Drug Stores*, 973 F. Supp. at 67.

Here, State Farm is the employer which established and maintained a program of health benefits for its employees and their dependants. See *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) ("a plan, fund or program falls within the ambit of ERISA only if the plan, fund, or program covers ERISA participants because of their employee status . . . and an employer . . . is the person that establishes or maintains the plan, fund, or program."). State Farm's employee benefits plan is the ERISA plan involved in this case. Carle Clinic and HAMP provide medical services to the ERISA plan; they are not the plan itself. State Farm pays for the services which Carle Clinic and HAMP provide to patients when those patients are State Farm employees, but that does not turn Carle Clinic's or HAMP's actions in running its own medical plan into actions

²¹ "[G]eneral state contract, zoning or tort legislation can surely affect the options available to ERISA plans without thereby being preempted." *American Drug Stores*, at 66.

taken by an ERISA plan, nor does it turn Carle Clinic or HAMP into a fiduciary.²²

To the contrary, Petitioners were acting in their capacities as medical entrepreneurs, not as an ERISA plan or any other ERISA-governed entity. In instituting bonus policies for physicians, and in failing to inform Ms. Herdrich of those policies, Petitioners were not acting as administrators determining eligibility for benefits or as fiduciaries managing plan assets or other plan administration. ERISA § 3(21), 29 U.S.C. § 1002(21). Instead, the bonus arrangement between HAMP and Carle Clinic doctors is like the provider agreements in *Blue Cross*, contractual promises between the HMO and its participating physicians having only the most tenuous connection with an ERISA plan. *Blue Cross*, 187 F.3d at 1051. Petitioners admit that when "HMOs and other health care providers make myriad discretionary judgments . . . [m]any such judgments – including the cost-containment mechanism adopted – have no direct impact on the benefits provided by an ERISA plan." Pet. 11. This admission flatly shows that the Petitioners themselves do not believe that they were acting as ERISA fiduciaries when instituting the compensation policies which were challenged by Ms. Herdrich under state law. Like the HMO in *In re U.S. Healthcare*, Carle Clinic and HAMP instituted business policies which allegedly impacted the provision and arrangement of medical care in a manner which adversely affected the medical judgment of its physicians. *In re U.S. Healthcare*, at *10. In its preemption arguments, HAMP asserted that, if successful, Ms. Herdrich's state law claims would require HAMP to become the "guarantor of the quality of care paid for by the Plan." Res. App. 36a. ERISA's civil enforcement provisions simply do not address quality of care issues. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3rd Cir.1995).

²² "[A] person is a fiduciary with respect to a plan to the extent . . . he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or dispositions of its assets . . . or . . . he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21).

HAMP and Carle Clinic could not have been sued in any ERISA capacity under any of the "six carefully integrated civil enforcement provisions" set forth in § 502(a) because the claims against Petitioners were for their actions in creating incentive arrangements which allegedly breached contractual duties owed to patients and for alleged unfair consumer trade practices, not actions taken in administering employee benefits or managing the plan's assets. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 n.3 (1985). Thus, Ms. Herdrich's state law claims could not be brought under ERISA's civil enforcement provisions, there was no federal court jurisdiction, and her state law claims were improperly removed to federal court. *Metropolitan Life Ins. Co.*, 481 U.S. at 63 (1987); *Toumajian*, 135 F.3d at 657; *Rice*, 65 F.3d at 646.

C. Where HMOs Act as Medical Entrepreneurs Rather than in an ERISA Capacity, There Is No ERISA-Governed Relationship and State Laws Regulating Them as Such Are Not Preempted By Section 514(a) of ERISA.

A review of this Court's recent cases interpreting ERISA's express preemption clause provides support for *amici's* position that there is no jurisdiction over this action.²⁷ With its unanimous decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), this Court signaled a shift in its ERISA preemption analysis. It held that courts must start with the presumption

²⁷ ERISA § 514(a), 29 U.S.C. § 1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." In its first ruling, the district court did not have the benefit of this Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), and its second ruling was made only three months after the first of these cases, *Travelers*. Instead, the district court relied solely upon *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), a case involving state mandated benefit laws, which are not at issue here.

"that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 655.¹⁰⁷

California Division of Labor Standards Enforcement v. Dillingham Construction, 519 U.S. 316 (1997), reinforced the presumption against preemption set forth in *Travelers*. In *Dillingham*, this Court held that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. *Id.* at 331. *Dillingham* reaffirmed that a state law only "relates to" an ERISA plan if it refers to or has a significant connection with an ERISA plan.

In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine whether the type of state law at issue is one that Congress would not have intended to preempt and then analyze the effect the state law has on ERISA plans. *Id.* at 332.

If ERISA were concerned with any state action--such as medical-care quality standards or hospital workplace regulations--that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's preemptive reach.

Id. at 329. Moreover, if the law merely "alters the incentives" which exist for an ERISA plan, "but does not dictate the choices," then the law is not sufficiently connected with an ERISA plan to require preemption. *Id.* at 333.

¹⁰⁷ This assumes of course that the state law does not refer to an ERISA plan or fall into one of the three types of state laws which are always preempted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. See *Travelers*, at 657-58, 660.

In *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), this Court emphasized the new preemption paradigm, concluding that any law “that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.” *Id.* at 816. Here, where the state law claims at issue invoke traditional areas of state concern and do not impact relationships regulated by ERISA, they are neither preempted nor form a proper basis for removal.

In keeping with this Court’s approach to ERISA preemption, the lower courts generally have found that medical malpractice claims against HMOs are not preempted and/or have been improperly removed from state court.¹¹⁷ Moreover, medical malpractice claims against HMOs as medical service providers to ERISA plans are analytically indistinguishable from malpractice claims against other types of service providers to plans such as actuaries, attorneys and investment advisers.

¹¹⁷ *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (claims against administrator of plan under theory of respondeat superior based on malpractice of provider on list designated by plan, not on negligent selection of that provider, did not provide basis for removal); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (vicarious liability claims against HMO based on malpractice of one of its treating physicians in treating patient were not preempted); *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 116 S. Ct. 1876 (1996) (medical negligence claims against HMO’s improperly removed); *Lupo v. Human Affairs International Inc.*, 28 F.3d 269 (2d Cir. 1994) (malpractice and breach of fiduciary duty claims based on doctor-patient relationship and infliction of emotional distress claim against managed psychotherapy care entity based on actions of its psychotherapist-employee improperly removed); *Pappas v. Asbel*, 724 A.2d 889 (Pa. Supreme Ct. 1998), *petition for cert. pending sub. nom. United States Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Co., et al.*, 67 U.S.L.W. 3717 (May 13, 1999) (No. 98-1836) (vicarious liability malpractice claim against HMO based on delay in transferring patient to an authorized facility was not preempted as “negligence laws have only a tenuous . . . connection with ERISA covered plans, . . . and therefore are not preempted”). (Internal punctuation and citations omitted.)

Courts have held repeatedly that state law claims against these non-fiduciary service providers are not preempted.¹²⁷

The rationale for such results is obvious. Nothing in ERISA or its legislative history evinces a clear legislative intent to preempt traditional state laws of general applicability that do not affect the relations among the principal ERISA entities – the employer, the plan fiduciaries, the plan, and the beneficiaries. *See e.g., Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715, 724 (9th Cir. 1997); *Custer v. Sweeney*, 89 F.3d 1156, 1167 (4th Cir. 1996). When a state law does not regulate an ERISA-governed relationship, it will not be preempted.¹²⁸ *See id.*; *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (law affecting the relations between an ERISA entity and an outside party is not preempted). Quite simply, if there is no regulation of an ERISA-governed relationship, more likely than not, there will be no significant effect on the structure, administration, or the type of benefits provided by the plan. *Id.*

Likewise, if the principal ERISA entities are not being regulated in their ERISA capacities, then there is no ERISA-governed relationship. *Arizona State Carpenters*, 125 F.3d at 724; *cf. John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 106 (1993) (an insurance company acting as an investment manager of plan assets must comply with fiduciary standards). Conversely, but analytically parallel,

¹²⁷ *See, e.g., LeBlanc v. Cahill*, 153 F.3d 134 (4th Cir. 1998) (investment adviser); *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715 (9th Cir. 1997) (bank as non-fiduciary plan asset custodian); *Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996) (insurance agent); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996) (attorney); *Airparts Co. v. Custom Benefit Services*, 28 F.3d 1062 (10th Cir. 1994) (consultant); *cf. Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990) (health care providers’ state law claims against plan not preempted).

¹²⁸ Courts generally only reach the issue of an ERISA-governed relationship after they determine that the state law at issue does not fall into one of the types of three state laws that are always preempted. *See supra*, n. 10.

this Court has recognized that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are against the plan in a capacity other than as a plan -- i.e., as a commercial entity -- and are not preempted. *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 833 (1988).

None of Ms. Herdrich's original state law claims concern Petitioners acting in an ERISA capacity -- that is, these claims do not impact plan administration or the payment of benefits. Instead, Carle Clinic and HAMP are in the business of providing medical services and Ms. Herdrich is a consumer of such services. A provider-consumer relationship does not fit within the traditional ERISA relationships. Instead, the relationship between Ms. Herdrich and Carle Clinic and HAMP is much closer to commercial relationships where claims have been held not to be preempted. *Mackey*, 486 U.S. at 833; *Arizona State Carpenters*, 125 F.3d at 724; *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471 (4th Cir. 1996). The state claims at issue, which protect consumers against fraud and protect third party beneficiaries of contracts from bad faith and unfairness, cannot be preempted because those claims do not significantly impact any ERISA-governed relationship.¹⁴

Moreover, the state law claims at issue here involve areas of traditional state concern. Consumer protection laws -- be they common law or statutory enactments -- are areas of traditional state regulation where courts must presume that ERISA does not preempt the state's police power unless Congress has made clear its intent to do so. *Travelers*, 514 U.S. at 655; *Dillingham*, 519 U.S. at 325. Outside the ERISA context, this Court has acknowledged that state laws relating to fraudulent business dealings are an area of traditional state regulation. For example, in *Cippolone v. Liggett Group*, 505 U.S. 504, 516

¹⁴ The Seventh Circuit described the Illinois Consumer Fraud Act as a "set of general business norms" and an "all-purpose truth-in-business statute." *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) (although the court found that ERISA preempted claim that deceptive information was provided, this decision was pre-*Travelers*, and there was no finding whether the HMO was an ERISA entity).

(1992), state law claims relating to fraudulent and/or misleading information from a cigarette manufacturer that were unrelated to the advertising or promotion of cigarettes were held not preempted by federal law regulating cigarette warning labels and advertisements. The state consumer protection laws that were not preempted were, generally, fraud-type claims, including claims of failure to warn, breach of express warranty, breach of the duty not to make false statements of material fact or to conceal such facts, and conspiracy to misrepresent or conceal material facts. *Id.* at 530-31.

In recent ERISA cases, courts have recognized that similar state law fraud claims are exercises of traditional state power which are not preempted. See *Woodworker's Supply, Inc. v. Principal Mutual Life Insurance Company*, 170 F.3d 985, 991 (10th Cir. 1999) (state unfair trade practices act and fraud claim not preempted because claim of fraudulent inducement against insurer was based upon its role as seller of insurance, not its role as administrator of plan); *Wilson v. Zoellner*, 114 F.3d 713 (8th Cir. 1997) (state law of negligent misrepresentation not preempted); *Morstein v. National Insurance Services, Inc.* 93 F.3d 715, 722 (11th Cir. 1996) (state law claim of fraudulent inducement to enter into ERISA plan not preempted); *Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (same).

Like the claims in *Cippolone* and other recent ERISA cases, the state laws at issue here require nonfraudulent dealing in contracts and business practices and are an exercise of the traditional state police power to prohibit fraud. Consequently, the state law claims at issue are not preempted because they are areas of traditional state regulation and Petitioners are not ERISA-governed entities for purposes of the state law allegations.

II. ERISA FIDUCIARIES ARE LIABLE TO THE PLAN FOR RESTITUTION OF BONUSES AND PROFITS WHICH THEY GAIN BY THEIR COMMISSION OF FIDUCIARY BREACHES.

Assuming that this Court finds that the district court had subject matter jurisdiction and that Ms. Herdrich alleged

cognizable claims under ERISA's fiduciary duty rules, then she is entitled to seek restitution or disgorgement of profits on behalf of the plan. 29 U.S.C. §§ 1109 & 1132(a)(2); *Mertens v. Hewitt Associates*, 508 U.S. 248, 256, 260, 262 (1993). Although Ms. Herdrich did not specify in her Complaint under which subsection of ERISA § 502(a) she was proceeding, a close reading of the Complaint confirms that she was proceeding under ERISA § 502(a)(2), 29 U.S.C. § 1132 (a)(2). The Seventh Circuit read the Complaint as such. See *Herdrich*, 154 F.3d at 380. Ms. Herdrich requested relief on behalf of the plan, and she may only obtain such under ERISA § 409, as enforced through § 502(a)(2).^{15/}

"Section 409 reflects ERISA's adoption of common law trust principles." *Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406, 1411 (9th Cir. 1988); see generally *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1986) ("Rather than explicitly enumerating all of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility."). ERISA § 409 establishes that plan fiduciaries are personally liable to the plan to make good to the plan any losses resulting from a fiduciary breach and to restore to the plan any profits from that breach. 29 U.S.C. § 1109. This provision permits other remedies that make the plan whole or otherwise cure the breach, such as removal of a fiduciary and is consistent with ERISA's goal of protecting employee benefit plans as entities unto themselves. *Id.*; see *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). Accordingly, under traditional trust law principles and ERISA

^{15/} If the Court reaches the issue of remedies, amici suggest that the Court should not go beyond remedies available under § 502(a)(2). See, e.g., *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 139 n.5 (1985) (where this Court specifically stated what it was not deciding). The lower courts are currently grappling with a variety of remedy issues under § 502(a)(3), 29 U.S.C. § 1132(a)(3). Compare, e.g., *Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998), cert. denied, 120 S. Ct. 170 (1999) with *Strom v. Goldman, Sachs & Co.*, 1999 WL 639844 (No. 98-7090) (2d Cir. Aug. 24, 1999). These issues are not before the Court in this case.

§ 409, restitution and disgorgement are available as equitable remedies. *Mertens v. Hewitt Associates*, 508 U.S. at 256, 260, 262.

Under the RESTATEMENT (THIRD) OF TRUSTS, when trustees breach their duty of loyalty, beneficiaries may bring suit to recover any profits made by the trustees through the breach of their duties to the trust. RESTATEMENT (THIRD) OF TRUSTS, § 205(a)(1990). This is similar to interpretations of the duty of loyalty under ERISA. See *Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406, 1411 (9th Cir. 1988), quoting *Leigh v. Engle*, 727 F.2d 113, 122 (7th Cir. 1984); *Donovan v. Bierwith*, 680 F.2d 263, 271 (2d Cir. 1982); *Eaves v. Penn*, 587 F.2d 453, 457 (10th Cir. 1978). The fundamental reason for such a rule is to act as a deterrent against fiduciaries engaging in disloyal conduct by denying them the profits of their breach. G. T. Bogert, TRUSTS, *Creation of Constructive Trusts* § 87 (6th ed. 1987) (where the fiduciary has violated the duty of undivided loyalty a constructive trust may be imposed; this applies to prevent any unjust enrichment of the trustee as a result of any breach of trust) (emphasis added).

Moreover, the RESTATEMENT (FIRST) OF RESTITUTION recognizes the special relationship which fiduciaries have with their beneficiaries. "A fiduciary who has acquired a benefit by a breach of his duty as fiduciary is under a duty of restitution to the beneficiary." RESTATEMENT (FIRST) OF RESTITUTION at § 138(1) (1936). As in the instant case, "[w]here a fiduciary in violation of his duty to the beneficiary receives or retains a bonus or commission or other profit, he holds what he receives upon a constructive trust for the beneficiary." *Id.* at § 197; accord, § 160, cmt. c. Significantly, this rule is applicable even if the profit received by the fiduciary is not at the expense of the beneficiary. Relief is not based on the harm done to the beneficiary, "but [instead] rests upon a broad principle of preventing a conflict of opposing interest in the minds of fiduciaries, whose duty it is to act solely for the benefit of their beneficiaries." RESTATEMENT (FIRST) OF RESTITUTION § 197 cmt. a (1936). Accord, G. T. Bogert, TRUSTS, *Creation of Constructive Trusts* § 86 (6th ed. 1987). It makes no difference whether the bonus was given to the fiduciaries to induce them

to violate their fiduciary duties or whether the bonus was received in good faith, as long as it was received for an act done by them in connection with the performance of their duties as a fiduciary. RESTATEMENT (FIRST) OF RESTITUTION § 197, cmt. a (1936).

Consistent with traditional principles of trust law and restitution as a form of equitable relief, courts have ordered disgorgement of profits obtained through a fiduciary breach to be paid to the plan as equitable relief. *Waller v. Blue Cross of California*, 32 F.3d 1337 (9th Cir. 1994); *Amalgamated Clothing*, 861 F.2d at 1411. In this case, Ms. Herdrich has requested disgorgement to the plan of the bonuses which the fiduciaries received due to their breaches. Her prayer for relief meets the definition of restitution, is equitable relief within the meaning of ERISA § 409, and should be granted.

CONCLUSION

For the foregoing reasons, AARP, National Senior Citizens Law Center and National Employment Lawyers Association urge the Court to hold that the district court lacked subject matter jurisdiction over Ms. Herdrich's state law claims because the claims could not be brought under ERISA's civil enforcement provisions, removal was improper, and the state law claims at issue should be remanded to state court. Should the Court find that the district court had subject matter jurisdiction and Ms. Herdrich has alleged cognizable claims under ERISA, then the Court should hold that ERISA fiduciaries are liable for restitution to the State Farm ERISA plan of bonuses and profits which they gained by commission of fiduciary breaches.

Respectfully submitted,

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IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION and
HEALTH ALLIANCE MEDICAL PLANS, INCORPORATED,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

**BRIEF OF *AMICI CURIAE* AMERICAN ASSOCIATION OF
HEALTH PLANS, THE HEALTH INSURANCE
ASSOCIATION OF AMERICA, THE ASSOCIATION OF
PRIVATE PENSION AND WELFARE PLANS, AND THE
CHAMBER OF COMMERCE OF THE UNITED STATES
IN SUPPORT OF PETITIONERS**

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TABLE OF CONTENTS

	<i>Page</i>
Table of Cited Authorities	ii
I. Statement Of Interest	1
II. Summary Of Argument In Support Of Petitioners' Brief On The Merits	3
III. Argument	4
A. The Decision Below Contravenes Public Policy Designed to Curtail Health Care Costs	4
B. The Decision Below Improperly Involves the Federal Courts in Plan Design Decisions ..	9
C. Financial Incentives in Managed Care Plans Benefit Both Patients and Physicians	12
D. Federal and State Law and Policy Mandate Cost Containment Measures in Health Plans	18
E. The Decision Below Misconstrues The Rights and Remedies Available under ERISA	23
IV. Conclusion	29
Appendix	1a

TABLE OF CITED AUTHORITIES

	<i>Page</i>
Cases:	
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<i>Cited Authorities</i>	<i>Page</i>
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<i>Cited Authorities</i>	<i>Page</i>
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42 U.S.C. § 300e(c)(2)(D)	19
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<i>Cited Authorities</i>	<i>Page</i>
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STEVEN FINDLAY & JOEL MILLER, NATIONAL COALITION ON HEALTH CARE, DOWN A DANGEROUS PATH: THE EROSION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES 4 (1999)	5, 7
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<i>Cited Authorities</i>	<i>Page</i>
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I. STATEMENT OF INTEREST

The American Association of Health Plans (AAHP) is a national association for the managed health care community.¹ Its membership includes health maintenance organizations (HMOs), preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 health plans serving nearly 140 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).²

The Health Insurance Association of America (HIAA) is a national association for private health insurance companies and an advocate for the private, market-based health insurance system. Its more than 260 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to 123 million Americans.

The Association of Private Pension and Welfare Plans (APPWP) is a broad based, non-profit trade association founded to protect and foster the growth of this Nation's privately sponsored employee benefit plans. The members of APPWP include both small and large employer sponsors of employee benefit plans, as well as plan support

¹ Counsel for the Amici were the sole authors of this brief. No person or entity other than Amici made a financial contribution to this brief.

² 29 U.S.C. § 1001 *et seq.*

organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants.

The Chamber of Commerce of the United States (the Chamber) is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations of every size, in every sector and region. An important function of the Chamber is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the business community. The ability of its member organizations to both provide and purchase affordable, quality healthcare is of vital importance to the Chamber's member organizations.

As representatives of the health plan, health insurance, and business community, Amici, AAHP, HIAA, APPWP, and the Chamber have a strong interest in the federal questions presented by this case under ERISA. The member organizations of Amici provide health benefits to employees or arrange for the provision of health care services to employee welfare benefit plans regulated under ERISA. Furthermore, many of the APPWP's and the Chamber's member businesses are purchasers of health care services.

Amici have joined together to file this brief in support of Petitioners' Brief on the Merits because of the court of appeals' novel interpretation of ERISA and that statute's established body of caselaw, as well as the extraordinarily destabilizing significance of the holding for

sponsors of employee welfare benefit plans, managed care organizations (MCOs), and health insurance issuers. Counsel for Petitioners, Virginia Seitz, Esq., and Counsel for Respondent, James R. Ginzkey, Esq., have given their consent for Amici to file this brief.

The Seventh Circuit's holding that health plan benefit design features, such as an HMO's use of cost-containment measures, can violate the fiduciary duty provisions of ERISA will have a dramatic adverse effect on the ability of the employee benefit plan community and the health care industry to provide quality care at an affordable cost. Creating ERISA liability for common plan design features will unnecessarily and materially drive up the cost of health care coverage, and will discourage employers from providing health care coverage to their employees.

II. SUMMARY OF ARGUMENT IN SUPPORT OF PETITIONERS' BRIEF ON THE MERITS

The holding of the Seventh Circuit Court of Appeals threatens the ability of the Nation's employers to provide comprehensive health benefits to all employees receiving health coverage through their employment. In essence, the lower court's holding, if allowed to stand, subjects normal and necessary cost containment mechanisms included in all health plans to challenge under both state tort law and ERISA, notwithstanding the fact that such cost containment measures are expressly encouraged and often are mandated by both state and federal laws and regulations.

There is no precedent to support the lower court's expansive interpretation of ERISA fiduciary status and of fiduciary conflicts. The decision below does violence to

both the intent and text of ERISA in that it (1) ascribes ERISA fiduciary status to entities that are neither designated as fiduciaries nor engaged in fiduciary conduct; (2) creates a new tort for "breach of fiduciary duty" that not only is without foundation in ERISA, but provides a platform for the award of punitive damages which are not available under the statute; (3) hinders plan sponsors, plan fiduciaries, managed care organizations and physicians from implementing legitimate and necessary strategies to avoid the unnecessary dissipation of a limited pool of health care dollars; and (4) discourages employers and others from maintaining benefit plans, inevitably increasing the ranks of the uninsured.

III. ARGUMENT

A. The Decision Below Contravenes Public Policy Designed to Curtail Health Care Costs

In an unprecedented and legally unsupportable decision, the Seventh Circuit transformed a garden-variety medical malpractice case into a serious threat to the economic viability of all health plans - private and governmental - which utilize managed care precepts to provide comprehensive coverage to Americans. The decision is all the more remarkable because it was unnecessary for the court of appeals to venture into health care policy-making in order to find a remedy for the plaintiff, who had already received a judgment for \$35,000 in her malpractice action against her treating physician.

The facts, as alleged by plaintiff Cynthia Herdrich, illustrate a classic example of a physician's improper medical judgment. Lori Pegram, a physician employed by

the Carle Clinic, examined Ms. Herdrich. The Carle Clinic owned the HMO of which Ms. Herdrich was a member by virtue of her husband's employee benefit plan. The court of appeals simply assumed that Dr. Pegram was involved in the administration of the HMO, despite the absence of any allegations asserting that Dr. Pegram's compensation as a physician employee of the Carle Clinic was affected in any way by her treatment decisions specific to Ms. Herdrich, or indeed by patient treatment decisions in general.

Although a mass was discovered in Ms. Herdrich's abdomen, her physician delayed eight days before providing her with a sonogram, resulting in a ruptured appendix and peritonitis. A divided panel of the Seventh Circuit improperly transformed that state-law based malpractice claim into a cognizable claim for breach of fiduciary duty under ERISA. The majority held that the mere allegation that an MCO uses cost-containment mechanisms that involve the participation of physicians who provide services to ERISA plan members states a claim for breach of fiduciary duty under ERISA.

Currently, over 160 million Americans depend upon privately sponsored employer health and welfare plans subject to ERISA for their health care coverage.³ Managed care programs have become fundamental to employer

³ See Peter T. Kilborn, *Insurers Raise Health Coverage Costs to New Highs*, THE TOPEKA CAPITAL-JOURNAL, December 20, 1998; see also STEVEN FINDLAY & JOEL MILLER, NATIONAL COALITION ON HEALTH CARE, DOWN A DANGEROUS PATH: THE EROSION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES 4 (1999) (stating that 61% of Americans receive health care coverage through their employer).

sponsored health plans.⁴ "Managed care" is a process by which parties responsible for paying for healthcare services (either directly or through arrangements with providers or independent companies) deliver high quality health care at a competitive price.⁵ The lower court's decision not only undermines that complex balancing process, but also has the potential to destroy it completely.

After a period of relatively stable health care costs, employers are once again facing health care inflation, and are beginning to withdraw their economic support of health and welfare plans, or are limiting their contributions to fixed amounts.⁶ Low-income workers, who can assume that burden less easily, are disproportionately affected by such employer cutbacks.⁷ The result: an increase in the number of Americans who are without health care

⁴ In 1995, nearly 75% of all individuals receiving coverage through employer-sponsored plans were enrolled in some form of managed care. See HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, GAO/HEHS-98-154, EMPLOYER-BASED MANAGED CARE PLANS: ERISA'S EFFECT ON REMEDIES FOR BENEFIT DENIALS AND MEDICAL MALPRACTICE 7 (1998).

⁵ See PETER R. KONGSTVEDT, *MANAGED CARE HANDBOOK* 8 (2d ed. 1993).

⁶ KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS, ANNUAL SURVEY 12 (1999)* ("KAISER SURVEY"). The survey notes that health insurance premiums for all employers increased an average of 4.8 percent in 1999, while smaller employers (with fewer than 200 employees) saw their premiums increase an average of 6.9 percent. Coverage rates were found to have stabilized at 66 percent, which the Kaiser Survey calls "a surprising finding when a rebound might have been expected given the strong national economy." *Id.* at 30.

⁷ See R. Kronick and T. Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, 18 *Health Affairs* 30, 33 (1999).

coverage, accompanied by uniformly pessimistic projections that costs will continue to increase if appropriate action is not taken.⁸

Given those projections, the timing of this broadside attack on cost containment mechanisms, which are a core element of this country's health care strategy, is unfortunate. The *Herdrich* decision, if not overturned, will be devastating to current efforts by Congress, the Executive Branch, and the private sector to contain health care costs while attempting to strike the proper balance between cost control incentives and responsibility to patients.

At present, an estimated 43 million Americans remain uninsured⁹ and projections are that one million additional people will become uninsured each year, despite the burgeoning growth in the U.S. economy.¹⁰ Economic and political factors have curtailed the availability of alternate governmental sources of health care coverage such as Medicaid and Aid to Families with Dependent Children.¹¹ As health care costs continue to rise (they are

⁸ See FINDLAY & MILLER, *supra* note 3, at 5.

⁹ See *id.* at 1; WILLIAM S. CUSTER, HEALTH INSURANCE ASSOCIATION OF AMERICA, *HEALTH INSURANCE COVERAGE AND THE UNINSURED* 3 (1999); *cf.*, KAISER SURVEY, *supra* note 6, at 30 (census bureau estimates that nearly 1 in 5 workers is uninsured).

¹⁰ See KENNETH E. THORPE, NATIONAL COALITION ON HEALTH CARE, *THE RISING NUMBER OF UNINSURED WORKERS: AN APPROACHING CRISIS IN HEALTH CARE FINANCING* 1 (1997); see also CUSTER, *supra* note 9, at 5 (estimating that approximately fifty-three million Americans will be uninsured by 2007).

¹¹ See FINDLAY & MILLER, *supra* note 3, at 10.

projected to reach \$1.5 trillion annually by 2002),¹² Congress and the state legislatures are desperately searching for alternative ways to assure coverage while simultaneously containing costs. The Seventh Circuit's decision will interfere with that goal because it will severely limit this country's ability to maintain, much less to expand, health care coverage, and to prevent a return to the health care cost hyper-inflation of the 1970s and 1980s.¹³ A return to hyper-inflation will be inevitable if health care providers cannot be involved as participants in health care planning, with a meaningful stake in the overall effort to intelligently manage the cost and provision of healthcare services.

The court of appeals' decision exacerbates the crisis by effectively exempting medical professionals alone from the discipline of the marketplace. Judge Flaum, in dissent from the majority holding, recognizes the economic reality that private and public efforts to contain health care costs are necessary, and that those efforts must include all sectors of the health care industry, including medical professionals.¹⁴ The alternative is unacceptable: a return to "open checkbook" credibility medical reimbursement. The dissent also correctly points out that both federal and state

¹² See THORPE, *supra* note 10, at 2. HCFA estimates that total health expenditures will reach \$2.2 trillion by the year 2008. HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, NEW PROJECTIONS SHOW NATIONAL HEALTH SPENDING TO GROW MORE SLOWLY THAN PROJECTED LAST YEAR 1 (1999).

¹³ See CUSTER, *supra* note 9, at 4-5.

¹⁴ See *Herdrich v. Pegram*, ("Herdrich"), 154 F.3d 362, 380-84 (7th Cir. 1998) (Flaum, J., dissenting), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999), (Posner, J., Flaum, J., Easterbrook, J., and D. Wood, J., dissenting), *cert. granted*, 120 S. Ct. 10 (1999).

law are replete with measures allowing and even mandating cost-containment measures, and that supervision of employer-sponsored benefit plans and managed care constitutes a legislative and regulatory function that the courts are administratively ill-equipped to perform.

With the Seventh Circuit's opinion as one of the rare exceptions, the federal courts have wisely refrained from becoming mired in the complicated business of formulating health care laws and regulations, and should continue to follow that policy. The fact that managed care has its vocal critics does not in any way obligate the courts to create a novel application of the laws. Given the intense federal and state regulatory focus on this industry, Amici urge this Court to adopt the position that judicial restraint is the best recourse.

B. The Decision Below Improperly Involves the Federal Courts in Plan Design Decisions

In enacting ERISA, Congress did not intend the federal courts to substitute their views of what constitutes appropriate plan design for the judgments of employers and plan sponsors, who are not by statutory definition plan fiduciaries. The decisions of this Court and of the Courts of Appeal recognize that ERISA neither mandates nor specifies any substantive content for benefit plans.¹⁵

¹⁵ See, e.g., *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("[W]e are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits."); *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74, 78 (3d Cir. 1991) (ERISA does not mandate the substantive content of employee welfare benefit plans, and a court has no authority to draft their substantive content), *cert. denied*, 503 U.S. 938 (1992).

Nothing in ERISA precludes a health and welfare plan benefit design that provides incentives for health care professionals to be appropriately cost-conscious while fulfilling the obligations of their profession.

The *Herdrich* decision embodies the startling view that courts may impose their own opinions of benefit plan design and override the judgments of employers and plan sponsors. ERISA was intended to encourage employers and employee organizations to design and fund benefit plans in accord with their economic capacity.¹⁶ Its ERISA participant protections attempt to ensure that the appointed plan administrators and fiduciaries implement the plan *as designed and as set forth in the plan documents*.¹⁷ Consistent with ERISA's statutory purpose, the focus of its fiduciary provisions has been on plan administration,¹⁸ not design, and the pivotal query has always been: *In administering the plan, has there been a breach of ERISA's fiduciary duties?*

After *Herdrich*, however, there is authority to second-guess plan design as if it were a fiduciary activity. Not only does the Seventh Circuit's decision permit the courts to second-guess plan design and to hold plan sponsors liable as fiduciaries in connection with plan design, but it establishes an unprecedented and dangerous principle of ERISA fiduciary liability for service providers (like Dr. Pegram) and administrative managers -- entities traditionally considered among the class of non-fiduciaries.

¹⁶ ERISA § 1, 29 U.S.C. § 1001.

¹⁷ ERISA §404, 29 U.S.C. §1104.

¹⁸ ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1974).

As Judge Easterbrook remarked in his dissent from the Seventh Circuit's denial of rehearing *en banc*, the decision has far-reaching consequences:

If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies). . . are the principal features of HMOs and "preferred provider organizations."¹⁹

Those features, all designed to control the cost of providing health care benefits, have traditionally not been subject to judicial review. *Herdrich*, however, allows a plaintiff to challenge every single decision made in the context of establishing or administering a health plan as a "breach of fiduciary duty," including:

- Decisions respecting structural and administrative issues. These include routine business judgments, such as the selection of a specific health care delivery system and what form that entity will take.
- Decisions respecting benefit design and delivery. These include interpretations of policy exclusions or limitations, such as limiting benefits to "medically

¹⁹ *Herdrich v. Pegram*, 170 F.3d 683, 687 (7th Cir. 1999) (Easterbrook, J., dissenting), *cert. granted*, 120 S. Ct. 10 (1999).

necessary" care or excluding coverage for cosmetic surgery.

- Decisions of physicians and other health professionals respecting the appropriate type and level of care. Questions such as whether a person needs to be hospitalized, or whether a less expensive generic drug should be prescribed, can now be considered "fiduciary" in nature.

The Nation's employer-based healthcare system simply cannot function or indeed survive if every treatment decision made while implementing a managed care program is treated as a fiduciary decision made by a presumptively conflicted fiduciary. A significant component of health care costs paid for by ERISA plans consists of medical care providers' fees and charges. If the individuals who generate such charges cannot implement reasonable cost controls because the *Herdrich* decision has transformed such conduct into a fiduciary conflict, the employer-based health care coverage system will be adversely affected, to the detriment of millions of Americans.

C. Financial Incentives in Managed Care Plans Benefit Both Patients and Physicians

Over the last decade, in an effort to control costs, traditional fee-for-service medicine has largely been replaced in the American health care delivery system by a variety of forms of managed care, premised on encouraging both providers and enrollees to use limited health care dollars prudently.²⁰ Such financial incentives for providers

²⁰ See *supra* note 4.

can involve something as simple as hiring physicians on a flat salary, regardless of the number of medical procedures performed, or as intricate as risk-sharing arrangements, such as payments on a capitated basis (fixed per member per month payment), provider withholds, discounted fees with bonuses, and global rates. For health care consumers, they include responsibility for a portion of their medical bills through the almost universal use of deductibles and co-payments, as well as financial incentives to use qualified health care providers who can provide care in an economically efficient manner.

The court of appeals' view that physician incentive arrangements substantially erode the quality of American health care is both historically naïve and contrary to objective studies of the issue. First, the court failed to recognize that financial incentives were not born with the advent of managed care. In fee-for-service medicine, "there is a financial incentive to provide more services"²¹ -- perhaps even unnecessary services. More services, however, do not equate to better medical care, since they could be services that subject patients to a significant risk of complications and correlative diseases.²² Over-utilization of

²¹ Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence*, 53 MEDICAL CARE RESEARCH & REVIEW 294, 294 (1996); see also *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (commenting on the economic interests of treating physicians under a fee-for-service system).

²² See David W. Bates, et al., *Incidence of Adverse Drug Events and Potential Adverse Drug Events: Implications for Prevention*, 274 JAMA 29, 29 (1995) (stating that "over a million patients are injured in hospitals each year, and approximately 180,000 die annually as a result of these injuries").

health care services is a serious problem: the recent report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has estimated that overutilization of medical services might be as high as 30% of the total health care delivered in the United States.²³

Second, financial incentives are a "win-win" situation for everyone involved -- doctors, their patients, and benefit plan sponsors attempting to make the most of limited health care dollars. Such incentives "preserve the ability of physicians to individualize the care they provide their patients," at the same time they enlist physicians in the battle to control health care costs.²⁴ Incentives are also far preferable to alternatives, such as caps on specific services, which would limit physicians' ability to tailor their recommendations for care to the needs of the individual patient.²⁵

Most critically for patients, incentives have been proven effective in limiting costs²⁶ without any correlative detriment to the health care received by plan participants. Empirical data uniformly refute the court of appeals' position that reimbursement incentives exert a negative

²³ REPORT TO THE PRESIDENT OF THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS (1998).

²⁴ David Orentlicher, *Paying Physicians More to Do Less*, U. RICH. L. REV. 155, 164 (1996).

²⁵ *Id.* at 174.

²⁶ See Alan L. Hillman, et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 89 (1989).

impact on overall quality of care. In fact, the opposite is true: "the literature in this area, including large studies of Medicaid and Medicare patients in managed care systems in the 1980s, consistently shows that *costs are lower in managed-care systems, with quality equal to or better than that in fee-for-service care.*"²⁷

Statistically, for example, individuals like Ms. Herdrich who suffer from appendicitis fare better in an HMO than when their coverage is a traditional fee for service plan.²⁸ A study published in the *New England Journal of Medicine* revealed that ruptured appendices occurred in 34.3 percent of uninsured patients, 33.6 percent of Medicaid patients, 29.3 percent of patients with private indemnity insurance and in only 25.8 percent of the patients receiving care through managed care organizations.²⁹ Thus, the unsupported basis for the court of appeals' opinion -- an assumption that managed care physicians are likely to sacrifice patient care for their pocketbook -- is in direct conflict with the results of this empirical study which found that to a "significant extent, patients covered by fee-for-services plans . . . appear to be at a disadvantage as compared to those covered by capitated private plans."³⁰

Another recent study on quality of care in MCOs examined the comparative occurrence of preventable

²⁷ Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1228 (1996) (*emphasis added*).

²⁸ See Paula Breveman, *Insurance Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444, 449 (1994).

²⁹ See *id.* at 446.

³⁰ *Id.* at 449.

hospitalizations in managed care and fee-for-service populations. The study revealed that, with respect to four out of five medical conditions, the quality of care delivered by MCOs equaled or exceeded that delivered by fee-for-service plans. Of particular note with respect to the court of appeals' decision is the study's finding that the rate of hospitalization for a perforated appendix was lower for patients receiving care in a MCO.³¹

The court of appeals, however, selectively cites articles attacking managed care, while by-passing the many studies that credit managed care entities, especially for their effectiveness in preventive care and disease management. Studies published in the *Journal of the American Medical Association*, for example, indicate that HMO members receive more preventive care and more health-promoting activities than those using fee-for-service medical plans do.³² For especially vulnerable populations, including the poor or elderly, managed care has *improved* access and continuity of care as compared with traditional fee-for-service arrangements. For example, one study examining the impact of capitated payment arrangements on pregnant women and their newborns revealed that women whose obstetrical services were provided by physicians participating in a capitated arrangement were "*less likely to have a low-birth weight baby and not more likely to have*

³¹ *Quality of Care for Managed Care and Fee-for-Service Patients Based on Analysis of Avoidable Hospitalizations*, 2 VOLUME IN HEALTH (1999).

³² See Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1516 (1994).

other adverse pregnancy outcomes" than those receiving obstetrical care through a fee-for-service arrangement.³³

Yet another study demonstrated that Medicare participants in HMOs were diagnosed with cancers such as breast, cervix, colon, and melanomas at an earlier stage than participants with fee-for-service coverage:

Most preventive services are not covered under Medicare fee-for-service The greater availability of screening services in HMOs may be particularly important for the elderly because elderly women use screening mammographies and Pap smears less frequently than do younger women.³⁴

Perversely, the lower court believed that it was carrying the banner of physician responsibility "in determining what is the best course of treatment and therapy for their patients."³⁵ Its holding, however, works to create exactly the opposite result, effectively outlawing the very cost containment measures that cast physicians in the central role of directing, managing, and supervising medical care in the context of universally limited health care budgets. A significant benefit of a capitated system is that it transfers more control over medical decision-making to the hands of treating physicians, rather than leaving such decisions to the financing entity. Studies show that financial

³³ Gerald F. Riley, *Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees*, 84 AM. J. PUB. HEALTH 1602 (1994).

³⁴ *Demographic Predictors of Mammography and Pap Smear Screening in US Women*, 83 AM. J. PUB. HEALTH, 53-60 (1993).

³⁵ *Herdrich*, 154 F.3d at 377.

incentives in MCOs give physicians greater clinical autonomy to make decisions about how to reduce costs, while at the same time helping them to maintain quality.³⁶

The court of appeals' assumption that financial incentives will motivate physicians to cast aside their professional and ethical obligations does a disservice to the profession. The American Medical Association itself has guidelines that recognize that financial incentives are a fact of life, as long as they are interpreted to "promote the cost-effective delivery of health care and not the withholding of medically necessary care."³⁷ If we assume that physicians engage in acts that could constitute medical malpractice on the basis of financial motives, as the court of appeals has, then we should also abolish the fee for service system as a basis of compensation to health care providers, since it may also hold out a financial carrot to physicians to provide marginally appropriate treatments, or even unnecessary care.³⁸

D. Federal and State Law and Policy Mandate Cost Containment Measures in Health Plans

Neither Congress nor the states share the court of appeals' distaste for cost containment mechanisms. The

³⁶ See Orentlicher, *supra* note 24, at 164, 174-75; see Miller & Luft, *supra* note 32, at 1516.

³⁷ American Medical Association, *Council on Ethical and Judicial Affairs*, 273 JAMA 331 (1995); see also M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268 (1999). James C. Robinson, *Blended Payment Methods in Physician Organizations Under Managed Care*, 282 JAMA 1258 (1999).

³⁸ See *Herdrich*, 154 F.3d at 382 (Flaum, J. dissenting).

forms of financial risk sharing condemned by the court of appeals are all firmly grounded in legislative policy designed to eliminate the inflationary incentives of "open checkbook" medicine. Systems for the achievement of cost-savings in health care coverage and delivery have constituted the keystone of federal and state health care programs since the passage of the Federal Health Maintenance Organization Act of 1973,³⁹ which required employers with at least 25 employees to offer a federally qualified HMO as an option to their employees and which expressly authorizes HMOs to "make arrangements with physicians . . . to assume all or part of the financial risk."⁴⁰ ERISA itself specifically mandates that welfare plan fiduciaries are subject to a duty to act prudently and preserving and maintaining plan assets.⁴¹ Yet the court of appeals' decision would deny ERISA plans the ability to avoid wasteful expenditures of plan assets through cost control systems expressly sanctioned by federal and state laws.

Congress more than a decade ago shared the court of appeals' bias against MCO cost containment practices, and, at one time, prohibited prepaid health care organizations that contracted with Medicare and Medicaid from having incentive based payment arrangements with physicians.⁴² Research studies by the Department of Health

³⁹ 42 U.S.C. § 300(e) (1973).

⁴⁰ 42 U.S.C. § 300e(c)(2)(D) (Supp. 1999).

⁴¹ ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1).

⁴² Omnibus Budget Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. 2002 (1986). The Omnibus Budget Reconciliation Act (OBRA) of 1990, Pub. L. No. 101-508, §§ 4204(a),

and Human Services, however, "failed to find a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans."⁴³ Recently, based on empirical studies rather than uninformed supposition, the federal government released *Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Healthcare Organizations*, in which it aggressively promotes for inclusion in the Medicare and Medicaid programs the very cost containment methodologies that would be outlawed by the Seventh Circuit.⁴⁴

In the 26 years since the passage of the HMO Act, Congress has passed a series of acts and amendments with one goal: to regulate and to foster the growth of managed care programs in all forms of government sponsored health care delivery systems. For example, in 1981, the Omnibus Budget Reconciliation Act (OBRA '81)⁴⁵ helped foster managed care contracting with state Medicaid programs, an innovative approach which had at its core Medicaid's need to supply quality health care at a cost-effective price. The following year, the Tax Equity and Fiscal Responsibility Act (TEFRA)⁴⁶ allowed MCOs participating in the

1388-236 (1990), repealed the prohibition on physician incentive plans in Medicare and Medicaid HMOs.

⁴³ 57 FED. REG. 59,024 (proposed Dec. 14, 1992); Requirements for Physician Incentive Plans, 42 C.F.R. § 417.479 (1997).

⁴⁴ Social Security Act, 42 U.S.C. § 1395mm (Supp. 1999) (Medicare managed care); 42 U.S.C. § 1396b(m) (Supp. 1999) (Medicaid managed care); 42 U.S.C. § 1395w (Supp. 1999) (Medicare+Choice).

⁴⁵ OBRA of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981).

⁴⁶ TEFRA, Pub. L. No. 97-248, 96 Stat. 324 (1982).

Medicare program to enter into risk sharing contracts with health care providers. Since then, enrollment in MCOs with risk sharing arrangements by Medicare insureds has increased 10 times over,⁴⁷ to over 2 million members.⁴⁸

The question of whether and how best to further regulate commercial health plans is currently very visible on Congress's radar screen, with rigorous debate over methods to protect enrollees while at the same time encouraging provider incentive programs and other cost-containment mechanisms. The "Norwood-Dingell Bill,"⁴⁹ for example, passed by the House of Representatives in October of 1999, would regulate physician incentive arrangements by extending to all commercial health plans the requirements that are now imposed only on health plans that contract with Medicaid. In addition, Congress has already limited the use of one common cost-containment mechanism -- pre-existing condition exclusions -- through the Health Insurance Portability and Accountability Act of 1996.⁵⁰ Further recent legislation has been aimed at

⁴⁷ DOUGLAS A. HASTINGS ET AL., NATIONAL HEALTH LAWYERS ASS'N, FUNDAMENTALS OF HEALTH LAW 252 (1995).

⁴⁸ Managed care is also a critical element of the Federal Employees Health Benefits Program as well as the Civilian Health and Medical Program of the Uniformed Service ("CHAMPUS"). In 1988, for example, CHAMPUS beneficiaries were given the ability to choose among various forms of managed care, as well as the traditional indemnity programs.

⁴⁹ H.R. 2990, 106th Cong., 1st Sess., (1999)(including H.R. 2723)("Bipartisan Consensus Managed Care Improvement Act of 1999," or the "Norwood-Dingell Bill")

⁵⁰ Health Insurance and Accountability Act ("HIPAA") of 1996, Pub. L. No. 104-191, 110 Stat. 2945 (1996); ERISA § 701, 29 U.S.C. § 1171; Public Health Service Act, §§ 2701, 2741, 42 U.S.C. §§ 300gg, 300gg-41.

prohibiting physician incentives that may have the effect of limiting care in specified situations.⁵¹

In addition to existing and proposed regulations, the managed care industry itself has developed well-regarded self-regulating mechanisms, which employers and other consumers of health care can consult when purchasing health plans. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), for one example, mandates that HMOs have in place rigorous quality assurance programs. JCAHO standards encompass 410 individual benchmarks, including education, leadership, management of human resources and performance improvement.⁵²

As is evident, there are few more highly regulated and monitored areas of the United States economy than employer-sponsored health care plans and the managed care industry. Issues relating to how to provide medical care for both the insured and uninsured, while simultaneously controlling medical spending, is at present a subject of the

⁵¹ See Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (1996); Women's Health and Cancer Rights Act, Pub. L. No. 105-277, § 902, 112 Stat. 2681 (1998) (prohibits issuers from offering providers incentives to provide a patient with care that is inconsistent with the terms of the Act).

⁵² See also, National Committee on Quality Assurance (NCQA) "Surveyor Guidelines for the Accreditation of MCOs," UM 11.5 (Effective July 1, 2000-June 30, 2001); *The NCQA's Quality Compass: Evaluating Managed Care in the United States*, 17 Health Affairs 152 (1998). The NCQA evaluates HMOs based on internal quality processes, and requires complete disclosure of any incentives regarding utilization of medical services.

most intense public debate, and presents numerous intertwined (and sometimes conflicting) policy issues.

Yet the Seventh Circuit has concluded that all of the legislative, regulatory, and industry safeguards pertaining to an MCO's contracts with ERISA plans are inadequate to protect consumers appropriately. Its opinion disregards the considered judgment of federal and state legislatures and regulatory agencies that hold that physician incentives to control over-utilization and eliminate unproductive expenditures are appropriate and, indeed, necessary to sustain a health care system that employers and society can support. On the basis of undocumented assumptions about the alleged adverse impact of managed care cost containment practices, the court has turned a virtue -- the duty of an ERISA fiduciary to be financially prudent -- into a punishable sin, with dire consequences for the limited health care dollars of every plan.

E. The Decision Below Misconstrues The Rights and Remedies Available under ERISA

The court of appeals' decision creates a new class of fiduciary breach. It holds that physician incentives to manage health costs "*can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists. . . ." ⁵³ Apparently, a fiduciary need not actually have engaged in conduct that constitutes a breach of fiduciary duty in order for a court to find liability for such a breach. All that is required is an allegation that a plan participant no longer

⁵³ *Herdrich*, 154 F.3d 373 (emphasis added).

has faith in the fiduciary's ability to fulfill his or her statutory duties.

A participant's mere concern that a fiduciary *might* breach a duty, whether or not justified, does not constitute an actual breach under ERISA.⁵⁴ Despite an absence of evidence that Dr. Pegram engaged in any fiduciary activity, and despite the fact that ERISA does not govern physician-patient relationships on any level,⁵⁵ the court of appeals created this novel form of what is in effect an anticipatory hypothetical fiduciary breach.

The lower court's mistaken holding is based upon profound conceptual errors regarding the nature of the ERISA-based identities and relationships between the parties. First, the court confused the HMO with the plan sponsor of the ERISA-governed employee welfare benefit plan in which Ms. Herdrich participated. Second, it confused Dr. Pegram's activities, all of which involved patient care, with ERISA plan administration. Even if Dr. Pegram performed any administrative function (which is unlikely), action that consists of the ministerial implementation of a plan is not a fiduciary function.⁵⁶ These conceptual errors led to the erroneous conclusion that compliance with plan design can constitute a breach of fiduciary duty, and that the HMO's doctors participated in that breach because their compensation was based, in part,

⁵⁴ 29 U.S.C. §§ 1104 and 1109.

⁵⁵ See *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 249 (5th Cir. 1990) (ERISA governs relationships between employers, plans, participants, beneficiaries and plan fiduciaries).

⁵⁶ 29 C.F.R. § 2509.75-8, Q&A D-2.

upon implementing cost saving mechanisms that were included in the plan's design.⁵⁷

Apparently, the Seventh Circuit based its conclusion that the HMO and the Clinic physicians were fiduciaries upon its finding that they exercised discretion in the claims adjudication process,⁵⁸ despite a complete absence of evidence that they were fiduciaries for claims adjudication or for any other purpose. Fiduciary status is not an all-or-nothing proposition. A person is a fiduciary only to the extent that the particular activity performed is a fiduciary function.⁵⁹ Thus, as Judge Easterbrook noted in dissent from denial of a rehearing, the appropriate question should not have been whether the HMO and Dr. Pegram *ever* performed a fiduciary function, but whether they were performing as fiduciaries when they participated in the design of a plan that contained financial incentives to implement cost saving measures.⁶⁰ The answer must be no: implementation of the plan as designed and as set forth in the plan documents is not a fiduciary function.⁶¹

⁵⁷ Plan design is not a fiduciary act. See *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996) (employers do not act as fiduciaries when they adopt modify or terminate plan); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995) (same).

⁵⁸ *Herdrich*, 154 F.3d at 370.

⁵⁹ See, e.g., *Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996).

⁶⁰ *Clemmons v. Delo*, 177 F.3d 680, 687 (8th Cir.) *reh'g denied and petition for cert. filed sub nom. Clemmons v. Bowersox*, __ S. Ct. __, No. 99-6533 (U.S. Nov. 15, 1999).

⁶¹ *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608 (7th Cir. 1995).

The court of appeals' decision improperly marries two very different concepts: (1) statutory violations of ERISA and (2) personal injury compensable under state tort law. ERISA provides a remedy when a fiduciary improperly denies a benefit expressly provided for in a plan, while state tort law provides relief when a physician renders substandard care, just as damages were awarded to Ms. Herdrich in this case.⁶² Numerous state and federal courts have recognized that distinction, holding that claims which challenge the quality of medical services delivered through managed care organizations are cognizable under malpractice law, but that it is inappropriate to invoke ERISA as a basis for such claims.⁶³

The *Herdrich* decision stretches ERISA's language beyond recognition by converting ordinary tort claims into tort-based "breach of fiduciary duty" claims. This is not a benign invention. A fiduciary duty is owed to the plan members *in the aggregate*.⁶⁴ Elevating the fiduciary duty owed to the individual participants of an employee benefit plan far above the duty owed to the plan as a whole, the decision literally prevents fiduciaries from fulfilling their statutory duty to preserve and maintain plan assets.⁶⁵ The result: fiduciaries will be compelled to breach their

⁶² *Herdrich*, 154 F.3d at 367.

⁶³ See, e.g., *DeLucia v. St. Luke's Hosp.*, No. 98-6446, 1999 U.S. Dist. LEXIS 8124 (E.D. Pa. May 24, 1999); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3^d Cir. 1995); *Santitoro v. Evans*, 935 F. Supp. 733 (E.D.N.C. 1996).

⁶⁴ ERISA §404(a)(1).

⁶⁵ See *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); see also, *Central States, Southeast & Southwest Areas Pension Fund v. Central Transp., Inc.*, 472 U.S. 559, 569-70 (1985).

statutory duties, as they are forced to provide health care coverage arrangements without cost containment measures to appease individual plan members and to avoid liability for damages under this new judicially-created ERISA tort action. In the long run, of course, such an approach is counter-productive, as it depletes plan assets and inevitably places the health care benefits of those same plan members at serious risk.

There is no basis whatsoever in the text of statute or this Court's prior opinions for this novel tort-based "breach of fiduciary duty" claim, and this Court should not allow a court of appeals to create one. Although Ms. Herdrich purported to bring her claim "on behalf of the Plan,"⁶⁶ no financial loss to the plan flowed from Dr. Pegram's delay in scheduling Ms. Herdrich for medical services, and her personal loss provides no basis for remedial relief for the plan under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Nor can Ms. Herdrich rely on Section 409 of ERISA, 29 U.S.C. § 1109, which allows participants to bring claims against a plan fiduciary who causes injury to the plan, and requires that the breaching fiduciary "make good to such plan losses to the plan." Nowhere in Ms. Herdrich's complaint does she allege that *any* action on the part of the HMO caused a financial loss to "the Plan," and indeed she cannot. The plan would have realized a financial gain rather than a loss if it functioned as Ms. Herdrich alleged. Any cost savings realized as a result of physician incentives would necessarily *reduce* rather than *increase* the costs to the plan for purchasing health benefits.

⁶⁶ See *Herdrich*, 154 F.3d at 362.

By creating a cause of action for an anticipatory fiduciary breach, the lower court has engrafted new remedies onto the text of ERISA in violation of this Court's strict mandate to apply the language of the statute as written. This Court recently reaffirmed its prior teaching: "ERISA is a 'comprehensive and reticulated statute'...and is 'enormously complex and detailed...' [and] it should not be supplemented by extra-textual remedies."⁶⁷ Just as this Court has refused to adopt a "strained interpretation" of ERISA in the interest of fulfilling the statute's purpose of protecting plan members,⁶⁸ so it should refuse to allow the Seventh Circuit to invent a form of fiduciary breach that does not require conduct constituting a fiduciary breach, no matter how laudatory its motives.⁶⁹

The creation of a new fiduciary standard unsupported by ERISA is not a harmless aberration that will be recognized as such by other courts. The *Herdrich* decision can be invoked to support a claim for breach of fiduciary duty any time cost-saving mechanisms -- the essence of employer-sponsored health care plans and managed care -- are in place.⁷⁰ Yet health plan enrollees

⁶⁷ *Hughes Aircraft v. Jacobson*, 525 U.S. 432 (1999).

⁶⁸ *Mertens v. Hewitt Associates*, 508 U.S. 248, 261 (1993).

⁶⁹ See also *Mertens*, 508 U.S. at 251 ("[V]ague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the specific issue under consideration").

⁷⁰ *Herdrich* has already been relied upon to allow a breach of fiduciary duty claim against an HMO doctor on the basis of the perceived financial tension between the doctor's and clinic's financial well being and the patient's welfare. See *Neade v. Portes*, 710 N.E.2d 418, 424-25 (Ill. App. Ct. 1999); see also, *Petrovich v. Share Health Plan of Illinois*, 1998 U.S. Dist. LEXIS 8454 (E.D. Ill. Sept. 30, 1999).

already have a remedy for inadequate quality of medical services in medical malpractice law,⁷¹ and ERISA provides ample judicial remedies, including the availability of immediate injunctive relief.⁷² The court of appeals' unnecessary construct of a hybrid consisting of both ERISA fiduciary standards and medical malpractice tort principles must be rejected. The decision also constitutes impermissible "judicial policymaking" by repudiating the express policy determinations of Congress, the Executive Branch, and state legislatures mandating the provider risk sharing methodology at issue in this case. Most significantly, it irreparably harms the ability of ERISA fiduciaries, employers, plan administrators, and MCOs to sustain our current system of employer-based health coverage on which millions of Americans depend.

IV. CONCLUSION

For the above reasons, Amici, HIAA, AAHP, APPWP and the Chamber, respectfully request that this Court reverse the decision of the Court of Appeals for the Seventh Circuit.

⁷¹ See *DeLucia*, 1999 U.S. Dist. LEXIS 8124, at *10.

⁷² See 29 U.S.C. §1132(a)(1)(B).

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APPENDIX

**APPENDIX — COMPILATION OF RELEVANT
STUDIES AND ARTICLES**

(Omitted here but submitted separately
as Lodging Appendix)

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No. 98 - 1949

Supreme Court, U.S.

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In the
Supreme Court of the United States

**LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,**

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

**On Writ of Certiorari to the United States
Court of Appeals for the Seventh Circuit**

**BRIEF OF *AMICUS CURIAE* AMERICAN
MEDICAL ASSOCIATION IN SUPPORT OF
PETITIONER LORI PEGRAM, M.D.**

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TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	ii
INTEREST OF <i>AMICUS CURIAE</i>	1
SUMMARY OF ARGUMENT	3
ARGUMENT	6
I. When a physician performs clinical services, including making diagnostic, prescriptive, therapeutic or referral decisions, for a patient who is a participant in an ERISA plan, the physician is not acting as a fiduciary to the ERISA plan	6
II. A physician's compensation agreement with a managed care organization, under which he or she is paid for performing clinical services for patients who are ERISA plan participants, does not cause the physician to become a fiduciary to the ERISA plan	23
CONCLUSION	29

TABLE OF AUTHORITIES

CASES	PAGE(S)
<i>Amato v. Western Union Int'l Inc.</i> , 773 F.2d 1402 (2nd Cir. 1985), cert. dismissed, 474 U.S. 1113 (1986)	9
<i>American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.</i> , 973 F. Supp. 60 (D. Mass. 1997)	12-13
<i>Beddall v. State Street Bank and Trust Co.</i> , 137 F.3d 12 (1st Cir. 1998)	9
<i>Buckley Dement, Inc. v. Travelers Plan Adm'rs of Ill., Inc.</i> , 39 F.3d 784 (7th Cir. 1994)	10
<i>Curcio v. John Hancock Mut. Life Ins. Co.</i> , 33 F.3d 226 (3rd Cir. 1994)	9
<i>Dukes v. U.S. Healthcare, Inc.</i> , 57 F.3d 350 (3rd Cir.), cert. denied, 516 U.S. 1009 (1995)	14, 16, 22
<i>FMC Corp. v. Holliday</i> , 498 U.S. 52 (1990)	12
<i>Fort Halifax Packing Co. v. Coyne</i> , 482 U.S. 1 (1987)	7, 12, 16
<i>Goldfarb v. Virginia State Bar</i> , 421 U.S. 773 (1975)	22
<i>Herdrich v. Pegram</i> , 154 F.3d 362 (7th Cir. 1998), reh'g and reh'g en banc denied, 170 F.3d 683 (7th Cir. 1999)	<i>passim</i>

<i>Herrera v. Lovelace Health Sys., Inc.</i> , 35 F. Supp.2d 1327 (D.N.M. 1999)	14
<i>Hillsborough County v. Automated Medical Laboratories, Inc.</i> , 471 U.S. 707 (1985)	29
<i>Hughes Aircraft Co. v. Jacobson</i> , 119 S. Ct. 755 (1999)	10
<i>In re U.S. Healthcare, Inc.</i> , No. 98-5222, 1999 U.S. App. LEXIS 22464 (3rd Cir. Sept. 16, 1999)	12, 14
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	9
<i>LoPresti v. Terwilliger</i> , 126 F.3d 34 (2nd Cir. 1997)	9
<i>Mertens v. Hewitt Assocs.</i> , 508 U.S. 248 (1993)	10
<i>Metropolitan Life Ins. Co. v. Taylor</i> , 481 U.S. 58 (1987)	14, 21
<i>N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.</i> , 514 U.S. 645 (1995)	22
<i>Neade v. Portes</i> , 710 N.E.2d 418 (Ill. App. 1999), appeal docketed, No. 87445 (Ill. Oct. 6, 1999)	27
<i>Nealy v. U.S. Healthcare HMO</i> , 711 N.E.2d 621 (N.Y. 1999)	14

<i>Pacificare of Oklahoma, Inc. v. Burrage</i> , 59 F.3d 151 (10th Cir. 1995)	14
<i>Payonk v. HMW Indus. Inc.</i> , 883 F.2d 221 (3rd Cir. 1989)	9
<i>Phommyvong v. Muniz</i> , No. 3:98-CV-0070-L, 1999 U.S. Dist. LEXIS 3101 (N.D. Tex. March 11, 1999)	14
<i>Pilot Life Insurance Co. v. Dedeaux</i> , 481 U.S. 41 (1987)	21
<i>Reich v. Continental Cas. Co.</i> , 33 F.3d 754 (7th Cir. 1994)	10
<i>Reich v. Rowe</i> , 20 F.3d 25 (1st Cir. 1994)	10
<i>Rice v. Panchal</i> , 65 F.3d 637 (7th Cir. 1995)	14
<i>Rice v. Santa Fe Elevator Corp.</i> , 331 U.S. 218 (1947)	29
<i>Semler v. Oregon State Board of Dental Examiners</i> , 294 U.S. 608 (1935)	22
<i>Siskind v. Sperry Retirement Program</i> , <i>Unisys</i> , 47 F.3d 498 (1995)	9-10
<i>Swafford v. Harris</i> , 967 S.W.2d 319 (Tenn. 1998)	28
<i>Terry v. Bayer Corp.</i> , 145 F.3d 28 (1st Cir. 1998)	10
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	8

<i>Walling v. Brady</i> , 125 F.3d 114 (3rd Cir. 1997)	9
<i>Washington Physicians Service Association v. Gregoire</i> , 147 F.3d 1039 (9th Cir. 1998), <i>cert. denied</i> , 119 S. Ct. 1033 (1999)	24

STATUTES AND REGULATIONS

29 U.S.C. § 1001 <i>et seq.</i>	<i>passim</i>
42 U.S.C. § 11101 <i>et seq.</i>	18
42 U.S.C. § 11133(a)(1)(C)	20
42 C.F.R. § 462.1 <i>et seq.</i>	20
45 C.F.R. Part 60	18, 19
Fla. Stat. Ann. ch. 458.331 (West Supp. 1999)	18
225 Ill. Comp. Stat. 60/1 <i>et seq.</i> (West 1999)	17, 18
Ky. Rev. Stat. Ann. § 311.597(4) (Baldwin 1998)	28
N.Y. Educ. Law § 6509 (McKinney 1999)	18
Ohio Rev. Code Ann. § 4731.22(B)(18) (Baldwin 1999)	28

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Issues in Managed Care*, 273 JAMA
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Organizations: A Legal Perspective* (1994) . . . 17
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Manual for Hospitals* (1998) 21
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Staff Handbook: A Guide to Joint
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Care Organizations* (1999) 19
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External Influences and Controls*, 60 Law
& Contemp. Probs. 1 & 2 (1997) 17

INTEREST OF AMICUS CURIAE

With the written consent of the parties, reflected in letters on file with the Clerk of the Court, the American Medical Association ("AMA") submits this brief as *amicus curiae* in support of Petitioner Lori Pegram, M.D., pursuant to Rule 37 of this Court.¹

The AMA, the largest association of physicians in the United States, was founded in 1847 to advance the art and science of medicine and the betterment of the health of the American people. It sponsors a vast array of educational, scientific, and public health programs. These remain its purposes today. The AMA has promulgated "The Principles of Medical Ethics," a statement of basic rules for the ethical practice of medicine. Its Council on Ethical and Judicial Affairs ("CEJA") issues opinions which apply the Principles of Medical Ethics to specific ethical issues in medicine, including fees and charges, and the relationships and interests among physicians, patients and managed care organizations ("MCOs"). These opinions are collected in an AMA publication, the *Code of Medical Ethics*.²

¹ Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

² Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics* (1998-1999 ed.).

The AMA is concerned that, if uncorrected, certain portions of the opinion in the case before the Court³ might suggest that a physician can become a "fiduciary" under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA") when he or she (1) performs clinical services for patients who are participants in a plan subject to ERISA, or (2) receives compensation from an MCO in exchange for performing clinical services to patients who are participants in an ERISA plan.

Amicus can assist the Court in its resolution of the present case by identifying concerns raised by the decision below for the conduct of the practice of medicine, with reference to case law developments and relevant portions of the *Code of Medical Ethics*. *Amicus* will focus on the difference between duties of medical diagnosis and treatment and duties in the administration of employee benefit plans subject to ERISA. *Amicus* will suggest that clarification of the necessary elements for a claim of breach of ERISA fiduciary duty will allow lower federal courts to avoid the confusion over "fiduciary status" and "fiduciary duty" found in the decision below.

Amicus believes that a resolution of these matters by the Court will remove uncertainty over the implications of the decision below for the practice of medicine and properly restrict the application of ERISA to the operation of employee benefit plans, without intruding on the patient-physician relationship.

³ *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998) ("*Herdrich I*"), *reh'g and reh'g en banc denied*, 170 F.3d 683 (7th Cir.) ("*Herdrich II*"), *cert. granted*, 120 S. Ct. 10 (1999).

SUMMARY OF ARGUMENT

This case involves an "employee welfare benefit plan" subject to the Employee Retirement Income Security Act of 1974 (an "ERISA plan"). Such an ERISA plan is to be distinguished from the managed care arrangement utilized by the ERISA plan to provide benefits to the ERISA plan's participants and their beneficiaries. The opinion below infers that a physician who performs clinical services for patients who are participants in an ERISA plan is a "fiduciary" to the ERISA plan, either (1) by providing diagnostic, prescriptive, therapeutic or referral services for those participants, or (2) by receiving compensation in exchange for providing those services. These inferences are contrary to ERISA and would subject physicians—who are already heavily regulated within the medical profession and by external agencies—to tremendous uncertainty as to the legal standards applicable to their practice of medicine. Therefore, the Court should clearly reject all inferences in the opinion below that physicians who are performing clinical services for ERISA plan participants and who are being paid for those services are, solely for those reasons, fiduciaries to an ERISA plan and subject to ERISA's fiduciary duty rules in the context of the patient-physician relationship.

ERISA provides an "operational" test to determine fiduciary status. One is a fiduciary "to the extent" he or she performs acts described in the statutory definition. Further, ERISA's fiduciary duties apply only to conduct as a fiduciary. The only act identified as conferring fiduciary status in the present case was "deciding disputed benefit claims," which is arguably either exercising discretionary authority or control respecting

management of an ERISA plan, or having discretionary authority or responsibility in the administration of an ERISA plan. This Court has identified specific categories of actions which constitute administration of an ERISA plan, and lower federal courts have adopted this formulation. A physician's performance of clinical services within the patient-physician relationship is qualitatively different and clearly distinguishable from the categories of actions which constitute administration or management of an ERISA plan.

Therefore, the physician's performance of clinical services for patients who happen to be ERISA plan participants is not a fiduciary act under ERISA and is consequently not subject to ERISA's fiduciary duty rules. Moreover, there is no need to apply ERISA in order to regulate the patient-physician relationship, given the extensive regulation of the practice of medicine under State and federal law, as well as under internal mechanisms established by the AMA and other organizations within the medical profession, including State and local medical societies. Further, any implication that ERISA does apply to the patient-physician relationship would raise questions of preemption of relevant State laws, and would be inconsistent with the Court's recent ERISA preemption jurisprudence.

With respect to a physician's receipt of compensation under a managed care arrangement in exchange for treating patients who are participants in an ERISA plan, analysis also focuses on the physician's role with respect to the ERISA plan. Status as an ERISA fiduciary depends on the performance of actions described in the statutory definition of the term "fiduciary." The physician, in performing clinical services within the

patient-physician relationship, is engaged in acts which are qualitatively different and distinguishable from the actions which constitute administration or management of an ERISA plan, and is therefore not a fiduciary to an ERISA plan. The fact that the physician is being paid in no way changes the non-fiduciary character of the performance of clinical services; therefore, the receipt or ability to receive compensation for performing those clinical services does not impose fiduciary status or fiduciary duty on the physician. The public interest would not be served by using ERISA to regulate the compensation of physicians in the managed care environment. Physician arrangements with MCOs are subject to extensive State and federal regulation and scrutiny; in addition, the AMA has promulgated strict ethical guidelines relating to a physician's obligations in a managed care setting. Finally, any implication that ERISA regulates the compensation of physicians in the managed care environment would be wholly inconsistent with the Court's recent jurisprudence on ERISA preemption as well as its longstanding view that the regulation of matters of health and safety is a local concern.

For these reasons, the Court should also reject all inferences that physicians who are performing clinical services for ERISA plan participants and who are being paid for those services are, solely on that basis, fiduciaries to an ERISA plan and subject to ERISA's fiduciary duty rules in the context of the patient-physician relationship.

ARGUMENT

I. When a physician performs clinical services, including making diagnostic, prescriptive, therapeutic or referral decisions, for a patient who is a participant in an ERISA plan, the physician is not acting as a fiduciary to the ERISA plan.

Determining whether a person is a fiduciary under ERISA is a straightforward exercise in statutory construction. First, one must focus on the meaning of "plan" under ERISA. The statute defines a "plan" (or "employee benefit plan") to include an "employee welfare benefit plan," an "employee pension benefit plan" or a plan that is both. 29 U.S.C. § 1002(3).

The present case does not involve an employee pension benefit plan or a hybrid welfare benefit-pension benefit plan. It involves an "employee welfare benefit plan," which is defined in the statute as follows:

The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002(1) (emphasis added).

Thus, a medical benefit plan subject to ERISA: (1) is established or maintained by an employer (or employee organization, or both),⁴ (2) to provide medical, surgical or hospital benefits, (3) to plan participants and beneficiaries, (4) through the purchase of insurance or otherwise. In the case before the Court, a medical benefit plan was (1) maintained by State Farm, as an employer, (2) to provide medical benefits, (3) to participants and beneficiaries, including Respondent, (4) through CarleCare HMO, "a product of Health Alliance Medical Plans, Inc." Record at 93a.

A medical benefit plan established by an employer is the true "ERISA plan," and will be referred to as such herein. It is to be distinguished from products offered by health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), provider-sponsored organizations ("PSOs") and other MCOs, such as the HMO utilized by State Farm's ERISA plan. These are not ERISA plans; rather, they are commercial products of an MCO which are sold to ERISA plans. Sometimes these MCO products use the term "plan" or "health plan" in their name, but they are not ERISA plans—they are, instead, means through which benefits of an ERISA plan can be provided.⁵

⁴ Hereinafter, the term "employer" will include, where relevant, an employee organization or combination of employer and employee organization, to refer to the entity that establishes or maintains the plan.

⁵ "The words 'benefit' and 'plan' are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8 (1987).

To be a "fiduciary" under ERISA, one must have one of the statutorily-specified relationships to an ERISA plan:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added).

The phrase "to the extent" is critical. One is a fiduciary to an ERISA plan only to the extent that person engages in one of the acts described in the statute, with respect to an ERISA plan.

In *Varity Corp. v. Howe*, this Court recognized the importance of the "to the extent" limitation contained in the statute:

In relevant part, the statute says that a "person is a fiduciary with respect to a plan," and therefore subject to ERISA fiduciary duties, "to the extent" that he or she "exercises any discretionary authority or discretionary control respecting management" of the plan, or "has any discretionary authority or discretionary responsibility in the administration" of the plan.

Varity was *both* an employer *and* the benefit plan's administrator, as ERISA permits. . . .

But, obviously, not all of Varity's business activities involved plan management or administration.

516 U.S. 489, 498 (1996) (citations omitted, emphasis in original).⁶ See also *Herdreich II*, 170 F.3d at 685 (Easterbrook, J., dissenting).

A corollary to the rule that one has fiduciary status only "to the extent" one's actions are described in 29 U.S.C. § 1002(21)(A), is that ERISA's fiduciary duty rules⁷ are only applicable to the extent that one is acting as a fiduciary. In *Lockheed Corp. v. Spink*, this Court said: "only when fulfilling certain defined functions . . . does a person become a fiduciary under § 3(21)(A)," and "because [the] defined functions [in the definition of fiduciary] do not include plan design, an employer may decide to amend an employee benefit plan without being subject to fiduciary review." 517 U.S. 882, 890 (1996) (citing *Siskind v. Sperry Retirement*

⁶ See also *Beddall v. State Street Bank and Trust Co.*, 137 F.3d 12 (1st Cir. 1998); *Payonk v. HMW Indus. Inc.*, 883 F.2d 221, 225 (3rd Cir. 1989) ("[W]hen employers wear 'two hats' as employers and administrators, 'they assume fiduciary status only when and to the extent that they function in their capacity as plan administrators, not when they conduct business that is not regulated by ERISA.'" (quoting *Amato v. Western Union Int'l Inc.*, 773 F.2d 1402, 1416-17 (2nd Cir. 1985), cert. dismissed, 474 U.S. 1113 (1986))) (internal quotations omitted). *Accord LoPresti v. Terwilliger*, 126 F.3d 34, 40 (2nd Cir. 1997); *Walling v. Brady*, 125 F.3d 114, 119 (3rd Cir. 1997); *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 234 n.10 (3rd Cir. 1994).

⁷ 29 U.S.C. § 1104.

ment Program, *Unisys*, 47 F.3d 498, 505 (1995)) (internal quotations omitted) (brackets in original).⁸

Applying these rules to the fiduciary status of treating physicians, it is clear that nothing in ERISA could be read to indicate that Dr. Pegram, acting as a treating physician, was a fiduciary to State Farm's ERISA plan. Indeed, while the Seventh Circuit clearly held that Petitioners other than Dr. Pegram were fiduciaries, it is not clear whether Dr. Pegram was held to be a fiduciary to State Farm's ERISA plan:

We can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims.

Herdrich I, 154 F.3d at 370 (emphasis added). Dr. Pegram was not named in Count III of Respondent's Complaint;⁹ so, as a procedural matter, the decisions below should not apply to her or to other individual physicians.

⁸ See also *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999) (holding that respondent's fiduciary duty claims were "directly foreclosed by *Spink's* holding that without exception, '[p]lan sponsors who alter the terms of a plan do not fall into the category of fiduciaries.'" (citing *Spink*); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) (holding that ERISA does not authorize suits for money damages against a non-fiduciary for the non-fiduciary's participation in a breach of fiduciary duty); *Terry v. Bayer Corp.*, 145 F.3d 28, 35 (1st Cir. 1998); *Buckley Dement, Inc. v. Travelers Plan Adm'rs of Ill., Inc.*, 39 F.3d 784, 789-90 (7th Cir. 1994); *Reich v. Continental Cas. Co.*, 33 F.3d 754, 757-58 (7th Cir. 1994); *Reich v. Rowe*, 20 F.3d 25, 29-32 (1st Cir. 1994) (all holding, generally, that ERISA does not authorize suits for breach of fiduciary duty against non-fiduciaries).

⁹ *Herdrich I*, 154 F.3d at 366 & 367 n.3.

However, the opinion arguably implies, in several places, that individual physicians acted as ERISA fiduciaries:

[I]t is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

154 F.3d at 372 (emphasis added).

[I]ncentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

Id. at 373 (emphasis added).

[T]olerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of "loyalty" to his own financial interests.

Id.

[I]t is more likely than not that an incentive existed for the Carle doctors to abuse the dual loyalties that they observed in administering the Plan. . . .

Id. at 379 (emphasis added).

Despite these implications, the opinion never says that individual physicians were "deciding disputed claims" under State Farm's ERISA plan, which is the only type of discretion the Seventh Circuit identified as

conferring fiduciary status.¹⁰ By contrast, the physician acts described in the opinion involved treatment of patients. These clinical decisions are qualitatively very different from the decisions of ERISA fiduciaries in the administration or management of employee benefit plans. In the context of the Seventh Circuit opinion, though, physician decisions about the treatment of patients who are covered by an ERISA plan could be construed as involving ERISA plan administration. Any implication or suggestion to this effect should not be allowed to stand.

This Court has described the "administration" of employee benefit plans to include "obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax*, 482 U.S. at 9.

The Court of Appeals for the Third Circuit recently stated that:

[A]dministrative responsibilities over the elements of the plan [include] determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records.

In re U.S. Healthcare, Inc., No. 98-5222, 1999 U.S. App. LEXIS 22464, at *23 (3rd Cir. Sept. 16, 1999).¹¹

¹⁰ 154 F.3d at 370.

¹¹ See also *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 67 (D. Mass. 1997) (noting that *Fort Halifax* and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) "recognize a limited range of administrative functions (continued...)")

A physician's diagnostic, prescriptive, therapeutic or referral decisions (referred to herein as "clinical services") are entirely different from the duties of plan administration identified in *Fort Halifax*. The physician is not determining the patient's eligibility under the ERISA plan; the physician is treating a patient who has come for care. The physician is not calculating or determining benefit levels; the physician is determining which of the medical procedures available is best suited to the patient's specific condition. Neither is the physician making disbursements, calculating the level of funds for benefit payments or keeping records for ERISA plan reporting. Thus, the physician, in performing clinical services for patients, is not performing any act of ERISA plan administration or management, and therefore cannot be a fiduciary to the ERISA plan:

A surgeon exercises a great deal of discretion when deciding how (if at all) to perform an operation, but the fact that an ERISA welfare plan pays for the medical procedure does not make the physician a "fiduciary" of the patient

....

Herdreich II, 170 F.3d at 685 (Easterbrook, J., dissenting).

Numerous lower federal court decisions have recognized the qualitative and fundamental distinction between the practice of medicine and ERISA plan administration functions. These decisions have been made in cases which considered whether State court actions

¹¹ (...continued)

which are part of operating an employee benefit plan . . . eligibility determinations, benefit calculations, disbursements, fund monitoring [and] recordkeeping.").

based on, for example, negligence or wrongful death, in the treatment of an ERISA plan participant are preempted by ERISA. (The preemption argument in such cases may be based on 29 U.S.C. § 1132(a), as interpreted by this Court in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), on 29 U.S.C. § 1144, or on both provisions.) These cases distinguish between a claim based on the "quantity of care" an ERISA plan participant seeks and one based on the "quality of care" the participant receives. State law claims of the first type have been held to implicate ERISA plan administration (eligibility for benefits, level of benefits) and, therefore, to be preempted. The second type of State law claim, however, has been held to implicate medical decisions, or the implementation of those decisions and, therefore, has been found not to be preempted.¹²

This distinction is clearly articulated in a recent decision of the Court of Appeals for the Third Circuit:

Thus, it is the HMO's essentially medical determination of the appropriate level of care that the Baumans claim contributed to the death of their daughter. This is not a claim that a certain benefit was requested and denied.

In re U.S. Healthcare, No. 98-5222, 1999 U.S. App. LEXIS 22464, at *25 (3rd Cir. 1999) (emphasis added).

¹² See, e.g., *Rice v. Panchal*, 65 F.3d 637, 645 (7th Cir. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 154-55 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355-57 (3rd Cir.), cert. denied, 516 U.S. 1009 (1995); *Phommyvong v. Muniz*, No. 3:98-CV-0070-L, 1999 U.S. Dist. LEXIS 3101, at *7-8 (N.D. Tex. March 11, 1999); *Herrera v. Lovelace Health Sys., Inc.*, 35 F. Supp.2d 1327, 1330-32 (D.N.M. 1999); *Nealy v. U.S. Healthcare HMO*, 711 N.E.2d 621, 625 (N.Y. 1999).

This distinction between the performance of clinical services and the administration of an ERISA plan resolves the physician's ERISA fiduciary status. In performing clinical services for patients who happen to be ERISA plan participants or beneficiaries, the physician is not engaged in an act described in 29 U.S.C. § 1102(21)(A). Applying *Fort Halifax*, a physician would be engaged in ERISA plan administration, which can trigger fiduciary status, only to the extent he or she determines eligibility, calculates benefits, makes disbursements, monitors funds or keeps records for an ERISA plan.¹³

Absent fiduciary activity of the kinds described in the statute, ERISA's fiduciary duty rules are inapplicable. Failure to heed this principle led to the confusion in the opinion below. That opinion identifies a fiduciary act—"deciding disputed claims." *Herdreich I*, 154 F.3d at 370. However, the physician conduct which the Seventh Circuit described did not involve deciding disputed claims.

In order to avoid such confusion, this Court should reiterate that, to properly state a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that: (1) defendants have engaged in conduct described in 29 U.S.C. § 1002(21)(A) with respect to a plan covered by ERISA; (2) in the course of that conduct they breached their fiduciary duties; and (3) a cognizable loss resulted from that breach.

¹³ An individual physician could certainly become a fiduciary under an ERISA plan. He or she could, for example, be a member of the plan administration committee at the hospital or clinic where he or she is employed and, as a member, make decisions regarding eligibility of an employee or the level of benefits to which a participant is entitled. There is no allegation that Dr. Pegram played such a role in this case.

Under this formulation, which is consistent with the statute and prior decisions of this Court, the allegation that a person performed some fiduciary function for an ERISA plan will not imply that other, non-fiduciary conduct is subject to ERISA's fiduciary duty. Thus, a physician making a diagnostic decision concerning a patient covered by an ERISA plan (such as Dr. Pegram's decision that Respondent's condition did not warrant an immediate ultrasound) will not, by making such a diagnosis, be converted into an ERISA fiduciary:

Lori Pegram, a physician employed by Carle, scheduled Herdrich for an ultrasound examination in Urbana on one day rather than in Bloomington on another; that does not sound like an exercise of discretion "in the administration of [the] plan."

Herdrich II, 170 F.3d at 685 (Easterbrook, J., dissenting).

To convert a physician performing clinical services into an ERISA fiduciary makes his or her clinical conduct subject to ERISA rules and standards, but ERISA was never intended to regulate the practice of medicine:

The focus of [ERISA] thus is on the administrative integrity of benefit plans

Fort Halifax, 482 U.S. at 15.

When Congress enacted ERISA it was concerned in large part with the various mechanisms and institutions involved in the funding and payment of plan benefits.

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 357 (3rd Cir.), cert. denied, 516 U.S. 1009 (1995).

This is not to say that physicians should—or would—be unregulated in making medical decisions if those de-

cisions are not regulated by ERISA. For example, professional liability claims may be brought under State law whenever a patient believes the physician has violated any duties in the patient-physician relationship.¹⁴ Respondent, in fact, prevailed in such a claim:

Herdrich has recovered \$35,000 in damages for medical malpractice. She wants more. . . .

Herdrich II, 170 F.3d 683 (7th Cir. 1999) (Easterbrook, J., dissenting).

Professional liability is only one of many forms of regulation of physician conduct. Indeed, *amicus* believes that, between the external regulation of the practice of medicine under State and federal law, and the medical profession's own self-policing, no other profession is as extensively regulated as the medical profession.

The laws of each State define what constitutes the practice of medicine. They also define the criteria for licensure of physicians, establish a process for admitting physicians to practice, and set forth procedures for determining when they may no longer practice. Physicians are subject to disciplinary action (including fines, censure, reprimand, and loss of license) under the laws of every State if they fail to conform their services to national and local standards of care. See, e.g., Illinois Medical Practice Act of 1987, 225 Ill. Comp. Stat. 60/1 *et seq.* (West 1999).

¹⁴ See generally T. Metzloff & F. Sloan, *Medical Malpractice: External Influences and Controls*, 60 Law & Contemp. Probs. 1 & 2 (1997). See also Joel L. Michaels, American Medical Association, *The Regulation of Managed Care Organizations: A Legal Perspective* (1994).

Moreover, physicians who are disciplined by State medical boards or found liable in tort cases are, more and more frequently, listed in State databases and on agency websites for review by the appropriate regulatory body. Physician licensing and disciplinary codes, regulations, and board of medicine opinions in most States are complex and precise, covering physician conduct in every area of practice. Many States' disciplinary codes permit or require State medical licensure boards to exact penalties where physicians fail to adhere to broad standards regarding the quantity, type, method, or setting of diagnostic or treatment services or supplies, referrals, or medical management services. *See, e.g., Illinois Medical Practice Act of 1987, 225 Ill. Comp. Stat. 60/1 et seq. (West 1999); Florida Medical Practice Act, Fla. Stat. Ann. ch. 458.331 (West Supp. 1999); New York Medical Practice Act, N.Y. Educ. Law § 6509 (McKinney 1999).*

Physicians are also subject to multiple laws and guidelines that mandate conformance with rigorous quality and performance measures. For example, the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* ("HCQIA") and its implementing regulations impose a system of comprehensive scrutiny of physician quality. *See 45 C.F.R. Part 60, National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners ("NPDB").*

Under HCQIA, each State medical board must report to the NPDB specific information whenever it takes any action against a physician for reasons relating to a physician's professional competence, qualifications, conduct, or performance, which revokes or suspends licensure, censures or reprimands a physician or places him or

her on probation. HCQIA requires or permits reporting of adverse clinical privileges actions taken by health care entities and adverse professional membership actions taken by professional societies. 45 C.F.R. § 60.9 (1999). This requirement covers all settlements and judgments concerning professional liability (whether reported by professional liability insurers or hospital co-defendants) and corrective actions or discharges from hospital medical staffs. It further requires hospitals and permits other entities to query the NPDB in enumerated circumstances, such as when a physician applies for membership on a hospital's medical staff; when an MCO or other health care entity wishes to hire or contract with a physician, or comply with its own accreditation criteria; and for professional review activities. 45 C.F.R. § 60.10 (1999); 45 C.F.R. § 60.11 (1999).

Physicians are subject to extensive direct and indirect scrutiny and certification standards by private third-party accrediting bodies. For example, the National Committee for Quality Assurance ("NCQA") accredits physician organizations, requiring them to maintain high standards and rigorous quality measures in the following areas: administrative policies and procedures, MCO contracting capabilities, "Quality Management and Improvement," "Utilization Management," "Members' Rights and Responsibilities," "Preventive Health Services," "Credentialing and Recredentialing," and "Medical Records." National Committee for Quality Assurance, *Standards for the Accreditation of Managed Care Organizations* (1999). Within these categories of standards, individual criteria require compliance with specific dictates, such as making services accessible to patients, ensuring member satisfaction, providing chronic disease management and prevention services,

and conducting research to ensure efficacy of treatments. Increasingly, physician organizations will be unable to obtain MCO contracts without compliance with such third-party quality and care delivery standards. Moreover, even if physician organizations do not seek voluntary third-party accreditation from organizations such as NCQA, most MCOs do seek such accreditation, which typically requires the MCO to ensure compliance with these criteria in its contracts with physicians. National Committee for Quality Assurance, *Surveyor for the Certification of Physician Organizations* (1999).

In addition to these external restrictions on physician behavior, organized medicine imposes its own scheme of regulation of professional conduct. Physicians police themselves rigorously through professional certification and peer review. Physician societies, associations, hospital medical staffs, institutional review boards, specialty boards, and hospital committees all strictly regulate individual physician qualifications and service quality. Highly-developed peer review activities occur in hospitals and medical centers in which physicians undertake to evaluate each other. Such peer review has been granted credence in Medicare, Medicaid and other governmental programs for decades. 42 C.F.R. § 462.1 *et seq.* The AMA's Council on Ethical and Judicial Affairs may censure, suspend, or expel AMA members for a violation of the Principles of Medical Ethics or for other unethical or illegal conduct. AMA Bylaws, § 1.60. Other medical societies have similar disciplinary powers. Such disciplinary actions are reported to the NPDB, pursuant to 42 U.S.C. § 11133(a)(1)(C).

The majority of acute care institutional health care organizations implement organizational and governance

standards through voluntary accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), a quality oversight body for health-care organizations and managed care entities. JCAHO accreditation provides organizational and quality standards for medical staffs.¹⁵ Additionally, JCAHO performs routine inspections of accredited medical staffs to confirm adherence to its standards. Compliance with JCAHO requirements generally assures compliance with applicable federal and state requirements concerning the governance of medical staffs. Compliance with JCAHO standards also assures compliance with Medicare certification standards. Moreover, compliance with JCAHO standards provides another layer of external review and oversight over physicians' conduct.

Finally, *amicus* notes that the failure to distinguish physicians' clinical services from ERISA plan administration may create an inference that ERISA would preempt application of State regulation of the practice of medicine. The argument would be that, if physicians can be held to be acting as ERISA fiduciaries in performing clinical services to ERISA plan participants, ERISA provides a remedy for breaches of fiduciary duty,¹⁶ and that remedy preempts a State law cause of action arising out of the same conduct. See *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 63-67 (1987).

¹⁵ JCAHO, *Accreditation Manual for Hospitals* (1998); see also JCAHO, *The Medical Staff Handbook: A Guide to Joint Commission Standards* (1999).

¹⁶ See 29 U.S.C. §§ 1109, 1132(1), (2) and (3).

Such a result would be contrary to the statute and to prior decisions of this Court:

[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. . . .

N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 661 (1995) (citations omitted).

We find nothing in the legislative history suggesting that [ERISA] § 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants.

Dukes v. U.S. Healthcare, Inc., 57 F.3d at 357.

We recognize that the States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions.

Goldfarb v. Virginia State Bar, 421 U.S. 773, 792 (1975). See also *Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 611 (1935).

Nonetheless, such preemption claims could be made, if any implication were to remain that performing clinical services for patients who are ERISA plan participants is a matter of ERISA plan administration, subject to ERISA's fiduciary duty rules. Such an implication should not exist—nothing in the language or legislative history of ERISA suggests that it was ever intended to create a code for the practice of medicine.

For these reasons, *amicus* urges the Court to clearly reiterate the necessary elements of a claim for breach of fiduciary duty under ERISA and, in doing so, eliminate any implication that a physician making diagnostic and treatment decisions is acting as an ERISA fiduciary.

II. A physician's compensation agreement with a managed care organization, under which he or she is paid for performing clinical services for patients who are ERISA plan participants, does not cause the physician to become a fiduciary to the ERISA plan.

An employer may provide the benefits available under an ERISA plan "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Many employers provide the benefits available under an ERISA plan through a contract with an MCO. This is what State Farm did in the case before the Court.

An MCO puts together and markets managed care products (whose features typically include covered services, designated providers and compensation of providers) which can be utilized by ERISA plans or non-ERISA plans to provide benefits. These MCO products are not the ERISA plan. They are products purchased by ERISA plans. An ERISA plan can switch from one MCO product to another, or it can choose to provide benefits in a different way, such as through a group health insurance contract. The ERISA plan is still the ERISA plan, as distinguished from any product it uses to provide benefits.

This distinction was articulated in a 1998 decision of the Court of Appeals for the Ninth Circuit in a case

which considered whether ERISA preempted a Washington State statute which regulated the structure of MCO provider networks:

[T]he Act . . . does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy. . . . The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to "relate to" an employee benefit plan—just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans. After *Travelers*, ERISA plans no longer have a Midas touch that allows them to deregulate every product they choose to buy as part of their employee benefit plan. . . .

Accordingly, the mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it "relates to" an ERISA plan.

Washington Physicians Service Association v. Gregoire, 147 F.3d 1039, 1044-45 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999).¹⁷

When an ERISA plan uses an MCO's product to provide benefits, the employer may pay the MCO, or the MCO may be paid out of ERISA plan assets. The MCO, in turn, compensates its providers, including physicians.

¹⁷ See also *Herdrich II*, 170 F.3d at 686 (Easterbrook, J., dissenting).

As discussed at pages 6-23 of this brief, when a physician performs clinical services for a patient, the fact that the patient is a participant in an ERISA plan does not turn those clinical services into plan administration.

As discussed at page 8 of this brief, there is no fiduciary duty where there is no fiduciary act. Since the physician, performing clinical services, is not acting as a fiduciary to an ERISA plan, he or she cannot breach any ERISA fiduciary duty by being paid for performing those non-fiduciary services. The ERISA plan pays the agreed-upon price for the MCO product and, for that consideration, the MCO's physicians provide clinical services to participants in the ERISA plan. The physicians are paid for performing those clinical services. If a patient/participant is dissatisfied with the clinical services provided, there are ample means to seek redress.¹⁸ If the ERISA plan (or its employer sponsor) is dissatisfied with the services the MCO provides, it can switch to another MCO or some other means of providing benefits.¹⁹ Within this framework, nothing supports an inference that paying a physician for performing clinical services to ERISA plan participants makes the physician an ERISA fiduciary.²⁰ The opinion below, to the extent that it contains any implication to the contrary, must be rejected.

A physician's potential conflict of interest under some MCO compensation arrangements should not and would

¹⁸ See pages 16-21, *supra*.

¹⁹ *Herdrich I*, 154 F.3d at 382 (Flaum, J., dissenting).

²⁰ *Amicus* does not address whether this analysis would be the same where a physician is also an owner of an MCO.

not be unregulated as a result of the statutory limitations of ERISA. As described in the following paragraphs, the AMA has provided detailed guidance on a physician's ethical obligations regarding MCO compensation arrangements. This guidance is widely accepted, both under state law and in the medical profession's own self-regulation procedures.

Since 1986, CEJA has issued a number of opinions relating to ethical concerns that have been raised in connection with MCO arrangements.²¹ These opinions recognize that the fundamental ethical obligation of a physician is, at all times, to deal honestly with patients and not to place the physician's own financial interests above the welfare of his or her patients.²² The relationship of trust between a physician and a patient for whom he or she is providing clinical services creates an affirmative ethical obligation for the physician to disclose any prohibition on referral sources for diagnostic or therapeutic services the physician believes the patient's condition warrants, so that a patient can decide whether to incur out-of-pocket expenses or accept the referral sources covered by the MCO arrangement.²³ The physician has an ethical obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost. Neither the promise of financial reward nor the threat of financial penalties alters

²¹ See generally CEJA Ops. 8.13, 8.132, 8.135 and 8.137, *Code of Medical Ethics* at 143-49; Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995).

²² CEJA Op. 8.13(1), *Code of Medical Ethics* at 143.

²³ CEJA Op. 8.132, *Code of Medical Ethics* at 147.

these ethical disclosure obligations, where failure to disclose would deny a patient access to appropriate medical services.²⁴

When physicians are employed by or reimbursed by managed care plans that offer financial incentives to limit care, potential conflicts are created between the physicians' personal financial interests and the needs of their patients. The AMA's ethical guidelines warn physicians of financial incentives that extend beyond the permissible goal of promoting cost-effective delivery of health care and can result in the withholding of medically necessary care.²⁵ Physicians have an ethical obligation to assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care.²⁶ The ethical guideline specifies that physicians can satisfy this ethical obligation by assuring that the "managed care plan" provides adequate disclosure to patients enrolled in the "plan."²⁷ The ethical guideline, then, acknowledges the reality that physicians are often not in the best position to provide information regarding MCO financial arrangements. A typical physician sees patients covered by numerous MCO arrangements, all with different, and usually complex, rules. Such disclo-

²⁴ *Id.*

²⁵ CEJA Op. 8.13(3), *Code of Medical Ethics* at 144.

²⁶ *Id.* See *Neade v. Portes*, 710 N.E.2d 418, 427 (Ill. App. 1999), *appeal docketed*, No. 87445 (Ill. Oct. 6, 1999) (citing CEJA Op. 8.132).

²⁷ *Id.*

tures are most effectively provided by the MCO, either directly or through the ERISA plan.²⁸

If a particular procedure is not covered by an MCO product or if the MCO declines to authorize a procedure recommended by the physician, the physician has an ethical obligation to advocate for care he or she believes will materially benefit the patient, regardless of such restrictions.²⁹ These obligations are fundamental elements of the patient-physician relationship, regardless of whether the patient is an ERISA plan participant.

Every State requires that physicians maintain accepted standards of professional behavior. Such standards are frequently embodied in State licensing statutes and regulations as well as court decisions. The AMA's ethical guidelines are commonly recognized as an element of those professional standards. See *Code of Medical Ethics* (1998-1999 ed.). Ohio and Kentucky have explicitly required, by statute, that physicians practicing in those States conform to the AMA's Code of Medical Ethics. Ohio Rev. Code Ann. § 4731.22 (B)(18) (Baldwin 1999); Ky. Rev. Stat. Ann. § 311.597(4) (Baldwin 1998). Similarly, Tennessee has adopted the Code of Medical Ethics by regulatory policy. *Swafford v. Harris*, 967 S.W.2d 319 (Tenn. 1998). Even in those States that have not specifically adopted the AMA's ethical policies, its Code of Medical Ethics is persuasive authority that guides the judgments of individual physicians, courts, and regulatory agencies.

²⁸ CEJA Op. 8.132, *Code of Medical Ethics* at 147.

²⁹ CEJA Op. 8.13(2)(b), *Code of Medical Ethics* at 143.

Therefore, there is no public interest in stretching ERISA beyond its statutory limits in order to regulate how a physician is paid for performing clinical services for patients. Moreover, the implication in the Seventh Circuit opinion that ERISA applies to MCO compensation of physicians for performing clinical services might support arguments that existing regulation under "State law," as defined in 29 U.S.C. § 1144(c)(1), would be preempted by ERISA, even though such claims could not withstand scrutiny under this Court's recent preemption jurisprudence. See pages 21-22 of this brief. Indeed, this Court has long recognized that the regulation of the practice of medicine is essentially a State concern:

[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern.

Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707, 719 (1985) (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947)).

For these reasons, *amicus* urges the Court to specifically reject any implication in the decision below that a physician's compensation arrangement with an MCO, under which he or she is paid for performing clinical services with respect to patients who are ERISA plan participants, causes the physician to become a fiduciary to the ERISA plan.

CONCLUSION

For the foregoing reasons, *amicus* urges the Court, first, to clearly reiterate the necessary elements of a claim for breach of fiduciary duty under ERISA and, in

doing so, eliminate any implication in the decision below that a physician making diagnostic and treatment decisions is engaged in the administration of an ERISA plan. *Amicus* also urges the Court to specifically reject any implication in the decision below that a physician's compensation arrangement with an MCO, under which he or she is paid for performing clinical services with respect to patients who are ERISA plan participants, could cause the physician to become a fiduciary to the ERISA plan.

Respectfully submitted,

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IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit

**BRIEF OF WASHINGTON LEGAL FOUNDATION
AS AMICUS CURIAE IN SUPPORT OF PETITIONERS**

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Date: November 19, 1999

2085

QUESTION PRESENTED

Whether a health maintenance organization ("HMO") and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1104(a)(1), by implementing a managed care program in which the physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iv
INTEREST OF THE <i>AMICUS CURIAE</i>	1
STATEMENT OF THE CASE	3
SUMMARY OF ARGUMENT	4
ARGUMENT	5
I. THE COURT OF APPEALS FAILED TO DISTINGUISH AMONG PLAN DESIGN, MEDICAL, AND FIDUCIARY DECISIONS AND THEREBY APPLIED THE WRONG REGULATORY SCHEME TO PETITIONERS' ACTIONS	5
II. HMO DECISIONS MUST BE ANALYZED UNDER A FRAMEWORK THAT RECOGNIZES PLAN DESIGN, MEDICAL, AND FIDUCIARY DECISIONS SO THAT THE PROPER REGU- LATORY SCHEME IS APPLIED TO EACH DECISION	11
CONCLUSION	16

TABLE OF AUTHORITIES

Cases:	Page
<i>Addison v. Whittenberg</i> , 529 N.E.2d 552 (Ill. 1988)	7
<i>Corcoran v. United Healthcare</i> , 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992)	12, 13
<i>Curtiss-Wright Corp. v. Schoonejongen</i> , 514 U.S. 73 (1995)	6
<i>Herdrich v. Pegram</i> , 154 F.3d 362 (7th Cir. 1998)	3, 4, 7
<i>Hughes Aircraft Co. v. Jacobsen</i> , 119 S. Ct. 755 (1999)	6, 9, 15
<i>Libbey-Owens-Ford Company v. Blue Cross & Blue Shield</i> , 982 F.2d 1031 (6th Cir.), cert. denied, 510 U.S. 819 (1993)	8
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	6, 15
<i>Martin v. Blue Cross and Blue Shield of Virginia</i> , 115 F.3d 1201 (4th Cir.), cert. denied, 522 U.S. 1029 (1997)	9
<i>Massachusetts Mutual Life Ins. Co. v. Russell</i> , 473 U.S. 134 (1985)	10
<i>Petrovich v. Share Health Plan of Illinois, Inc.</i> , No. 85726, 1999 WL 773524 (Ill. Sept. 30, 1999)	7
<i>Pryzbowski v. U.S. Healthcare, Inc.</i> , No. 97-3097 (MTB), 1999 US Dist LEXIS 13907 (D.N.J. Sept. 8, 1999)	12
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	10

Page

Statutes:

Employee Retirement Income Security Act of 1974 ("ERISA")	<i>passim</i>
ERISA § 3(21), 29 U.S.C. 1002(21)	8
ERISA § 404(a)(1)(A),(B),(D); 29 U.S.C. § 1104(a)(1)(A), (B), (D)	8
ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)	10
ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2)	10
ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)	10
Women's Health and Cancer Rights Act of 1998, Pub. Law No. 105-277, 112 Stat. 2681-436 (1998)	6

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**BRIEF OF WASHINGTON LEGAL FOUNDATION
AS AMICUS CURIAE IN SUPPORT OF PETITIONERS**

INTEREST OF THE AMICUS CURIAE

The Washington Legal Foundation (WLF) is a non-profit public interest law and policy center with supporters nationwide, including many in Illinois.¹ While WLF engages in litigation and participates in administrative proceedings in a variety of areas, WLF devotes a substantial

¹ Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amicus*, contributed monetarily to the preparation and submission of this brief.

portion of its resources to advancing the interests of the free-enterprise system and to ensuring that economic development is not impeded by excessive litigation. To that end, WLF has appeared before this Court as well as other federal and state courts in cases raising tort liability issues arising under the Employee Retirement Income Security Act of 1974 ("ERISA"). See, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). WLF also has appeared in cases touching upon the effects of tort liability on the ability of health care providers to deliver quality service to the American public. See, e.g., *Rotella v. Wood*, No. 98-896 (decision pending, U.S. S. Ct.); *Medtronic, Inc. v. Lohr*, 518 U.S. 470 (1996).

WLF is concerned by the proliferation of suits against health maintenance organizations and their fiduciaries being brought pursuant to ERISA. WLF believes that such suits have the potential -- particularly when, as here, they are directed at physicians' individual treatment decisions -- to cause serious disruption to the delivery of quality, affordable health care.

WLF fully agrees with Petitioners both that the appeals court's decision misinterpreted ERISA and that -- by extending ERISA fiduciary responsibilities to encompass cost-containment mechanisms -- it will undermine efforts to ensure that quality health care is widely available at affordable costs. WLF also filed an *amicus curiae* brief in support of the petition for certiorari in this case.

WLF is filing this brief because of its interest in maintaining high-quality health care to all Americans. It has no interest in the outcome of this lawsuit or of any other suits raising similar issues. Because of its lack of direct

economic interests, WLF believes that it can assist the Court by providing a perspective that is distinct from that of any party.

WLF's brief is being filed with the consent of all parties. Copies of the letters of consent have been lodged with the Clerk of the Court.

STATEMENT OF THE CASE

Respondent Cynthia Herdrich received medical treatment from an employee benefit plan established by State Farm Insurance Company (her husband's employer) for its employees and their dependents. The plan provides benefits through a health maintenance organization ("HMO"). Petitioner Lori Pegram, M.D., is the HMO physician who treated Ms. Herdrich. Petitioner Health Alliance Medical Plans, Inc. ("HAMP") operates the HMO. Petitioner Carle Clinic Association ("Carle Clinic") owns HAMP. The physicians who provide services through the HMO own Carle Clinic. Under an agreement between State Farm and HAMP, HAMP received a fixed monthly amount for each participant in the State Farm plan in payment for services the HMO would provide to plan participants.

The Court of Appeals concluded that Carle Clinic and HAMP were fiduciaries under ERISA because they had the right to decide disputed claims of individuals covered by the HMO. *Herdrich v. Pegram*, Pet. App. 14a. Dr. Pegram was a fiduciary because she exercised discretion in rendering care to individuals covered by the HMO. *Id.* The Court of Appeals further found that the financial incentives under which the Petitioners operated as fiduciaries could give rise to a fiduciary breach where, as alleged by the Respondent,

a physician delays or withholds care to benefit herself financially. *Id.* at 20a.

SUMMARY OF ARGUMENT

WLF agrees with Petitioners' position that the Court of Appeals' decision below was incorrect and will have harmful and anomalous effects on the country's health care system if allowed to stand.

The decision below resulted from the application of ERISA's fiduciary provisions to decisions that are not properly governed by ERISA. ERISA's fiduciary provisions regulate the process of paying for benefits provided under an employee welfare benefit plan. ERISA's fiduciary rules do not regulate the benefits that will be provided under the plan nor the medical decisions of doctors for whose services the plans pay.

Unlike fee for service arrangements, where a participant obtains medical services from his or her own doctor and submits the bill to the plan for payment, HMOs embody both the medical services governed by state law and the payment mechanism governed by ERISA. Because HMOs play multiple roles, the nature of an HMO's decision can be mischaracterized, as happened in this case. Properly analyzed, however, ERISA and state law provide a framework for appropriately regulating the multiple functions of HMOs.

To assure that the various functions of HMOs are subject to the correct regulatory regime, courts should distinguish among three types of decisions made in connection with welfare benefit plans governed by ERISA:

(1) plan design decisions made by employers that sponsor the plans, (2) medical decisions made in connection with the treatment of patients covered by the plans, and (3) fiduciary decisions concerning payment for benefits under the plans. Only the last type of decision properly is governed by ERISA.

ARGUMENT

I. THE COURT OF APPEALS FAILED TO DISTINGUISH AMONG PLAN DESIGN, MEDICAL, AND FIDUCIARY DECISIONS AND THEREBY APPLIED THE WRONG REGULATORY SCHEME TO PETITIONERS' ACTIONS

Petitioners explain in their brief that the Court of Appeals incorrectly concluded that Petitioners acted as fiduciaries in establishing and implementing cost-containment measures for the HMO, and that the establishment and use of these measures may give rise to a breach of fiduciary duty under ERISA. The Court of Appeals' conclusions are wrong because they improperly expand the definition of fiduciary and mischaracterize plan design and a treating physician's medical decisions -- which are outside the bounds of ERISA's fiduciary provisions -- as fiduciary acts.

Determining that the decision below was wrong is only part of the task that faces the Court, however. The more difficult chore is providing guidance on whether and when ERISA will apply to actions taken by or attributed to HMOs. To permit HMOs to continue to use cost-containment measures -- one of the reasons for their existence -- it is necessary to distinguish among plan design

decisions left to the discretion of the employer that sponsors the plan, medical decisions involving individual patients governed by state law, and fiduciary plan payment decisions governed by ERISA.

The proper framework for analyzing this type of case requires, at the outset, a determination whether the conduct at issue was non-fiduciary conduct or fiduciary conduct.

"Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). "ERISA's fiduciary duty requirement simply is not implicated where [the plan sponsor], acting as the plan's settlor, makes a decision regarding the form or structure of the plan such as who is entitled to receive plan benefits and in what amounts." *Hughes Aircraft Co. v. Jacobsen*, 119 S. Ct. 755, 763 (1999). *Accord*, *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 100 (1995). Thus, decisions concerning the design of the plan, including, for example, the benefits the plan will provide, the method for delivering benefits, and any limits to benefits the plan will pay for, are not fiduciary decisions. With few exceptions,² employers are free to design a plan which does not pay for certain treatments or excludes coverage for certain types of illnesses and to enter into other arrangements to control the cost of the plan. These plan design decisions are business decisions that the employer sponsoring the plan makes, taking into

² E.g., Women's Health and Cancer Rights Act of 1998, Pub. Law No. 105-277, 112 Stat. 2681-436 (1998) (requiring group health plans to provide coverage for mastectomies and certain related benefits).

consideration the cost of benefits and the needs of its employees.

Medical decisions by treating physicians similarly are not governed by ERISA's fiduciary provisions. A decision concerning the individual treatment of a plan participant is a medical decision requiring a doctor to consider the needs of the patient, not the plan.³ See, e.g., *Addison v. Whittenberg*, 529 N.E.2d 552, 556 (Ill. 1988). "Physicians, of course, should not allow the exercise of their medical judgment to be corrupted or controlled. Physicians have professional ethical, moral, and legal obligations to provide appropriate medical care to their patients." *Petrovich v. Share Health Plan of Illinois, Inc.*, No. 85726, 1999 WL 773524, at *16 (Ill. Sept. 30, 1999). Whether the plan will pay for the treatment the patient needs is a separate question, which leads to fiduciary decisions.

Fiduciary conduct requires the exercise of discretionary authority or control respecting management of a plan or discretionary authority or responsibility in administration of

³ As noted in WLF's brief in support of the petition for a writ of certiorari, a physician burdened with ERISA's fiduciary duties in making individual treatment decisions would be required to temper his or her decisions regarding the appropriate treatment for individual patients by taking account of the financial impact a particular treatment recommendation might have on the plan as a whole and on the plan's participants as a group. Thus, a physician/fiduciary could rightly decide under ERISA to withhold expensive treatment from a near-terminal patient to conserve scarce resources for the benefit of the healthier majority of plan participants. These non-medical, financial considerations are the very considerations that the Court of Appeals thought should *not* influence physicians at the treatment level. *Herdreich v. Pegram*, Pet. App. 31a ("doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients.").

the plan. ERISA § 3(21), 29 U.S.C. § 1002(21). The final decision whether an employee benefit plan will pay for a particular treatment or condition generally is a fiduciary decision. *Libbey-Owens-Ford Company v. Blue Cross & Blue Shield*, 982 F.2d 1031, 1035 (6th Cir.), *cert. denied*, 510 U.S. 819 (1993) ("When an insurance company administers claims for an employee welfare benefit plan and has authority to grant or deny the claims, the company is an ERISA 'fiduciary' under 29 U.S.C. § 1002(21)(A)(iii).").

ERISA's fiduciary provisions were designed to address and are well-suited for regulating plan payment decisions. In making a payment decision, a plan fiduciary must consider only the interests of plan participants and beneficiaries, ERISA § 404(a)(1); use plan assets only to pay benefits and defray the plan's administrative costs, ERISA § 404(a)(1)(A); act prudently, ERISA § 404(a)(1)(B); and follow the terms of the plan document, ERISA § 404(a)(1)(D). 29 U.S.C. § 1104(a)(1)(A), (B), (D).

In contrast, these ERISA considerations plainly are not suited to regulate an employer's decisions concerning the type and amount of benefits it will provide to its employees, or a doctor's decisions concerning proper medical treatment.

Under ERISA's regulatory scheme, a plan administrator's decision that the plan will not pay for a benefit that clearly is covered by the terms of the plan could be a breach of fiduciary duty. On the other hand, a plan administrator's decision that the plan will not pay for a benefit that clearly is not covered by the terms of the plan would not constitute a breach of fiduciary duty under ERISA, regardless of whether the benefit is necessary or appropriate for the

patient as a matter of medical judgment. *E.g.*, *Martin v. Blue Cross and Blue Shield of Virginia*, 115 F.3d 1201, 1209 (4th Cir.) (health plan participant not entitled to payment for treatment recommended by her physician but not covered under health plan), *cert. denied*, 522 U.S. 1029 (1997).

Analyzed under this framework, the Court of Appeals should have concluded that there was no fiduciary decision involved in Ms. Herdrich's treatment.

The financial incentives that the Court of Appeals found repugnant were negotiated by State Farm in establishing a benefit plan ("Plan") and deciding to provide benefits under the Plan through an HMO. Pet. App. 93a. Under the Plan's terms, except in the case of an emergency, services must be provided by the HMO's physicians and at the HMO's facilities. Pet. App. 1-2a, 103a. State Farm paid a fixed premium each month for each of its employees covered by the Plan. Pet. App. 98a-99a. All of these features are plan design features that State Farm chose in establishing the Plan for its employees and their dependents. These design features do not give rise to a breach of fiduciary duty. *Hughes Aircraft Co. v. Jacobsen*, 119 S. Ct. at 763.

The bad medical outcome that Ms. Herdrich suffered was caused by Dr. Pegram's medical judgment that Ms. Herdrich's condition did not require emergency treatment and the resulting decision not to send Ms. Herdrich to the emergency room for an immediate sonogram. In making this decision, Dr. Pegram was not making a judgment that the terms of the Plan did not cover emergency room treatment. Indeed, the Plan clearly permits emergency care

at a non-HMO facility when the physician determines that an emergency exists. Pet. App. 107a-108a. Respondent was not denied the emergency care she needed because of a plan payment decision. She was denied emergency care because Dr. Pegram made an erroneous medical judgment concerning her condition. Ms. Herdrich's claim concerning the treatment she received from the HMO and the HMO doctor therefore is subject to state law.

In fact, the case presented to the Court of Appeals did not involve any plan administration decision governed by ERISA's fiduciary rules because no plan fiduciary decided whether the Plan would pay for Ms. Herdrich's emergency room treatment.⁴ If, notwithstanding Dr. Pegram's medical judgment that emergency treatment was not necessary, Ms. Herdrich had gone to an emergency room, and then presented the bill for emergency treatment to the HMO for payment, the decision whether to pay for the treatment would be a fiduciary decision governed by ERISA. Because

⁴ Nor is Respondent in any event likely to recover anything for herself in an ERISA action alleging breach of fiduciary duty. A plan participant may bring two basic types of actions under ERISA: (1) an action for benefits due under a plan (ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)); or (2) an action to restore to the plan any losses the plan suffered as a result of a fiduciary breach (ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2)). A plan participant claiming that an ERISA fiduciary has breached a fiduciary duty to the plan generally may not recover monetary relief for his or her own benefit, however. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985) ("recovery for violation of [an ERISA fiduciary duty] inures to the benefit of the plan as a whole"). A plan participant claiming that an ERISA fiduciary has breached a fiduciary duty to the participant is limited (under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)) to an award of "appropriate equitable relief." *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996).

that did not happen in this case, no fiduciary claim arises from the HMO's treatment of Ms. Herdrich.

II. HMO DECISIONS MUST BE ANALYZED UNDER A FRAMEWORK THAT DISTINGUISHES AMONG PLAN DESIGN, MEDICAL, AND FIDUCIARY DECISIONS SO THAT THE PROPER REGULATORY SCHEME IS APPLIED TO EACH DECISION

HMOs, which were not widely used when ERISA was enacted in 1974, sometimes blur the distinction among the types of decisions made in connection with welfare benefit plans: what benefits are provided under the plan -- a plan design decision; what treatment is provided by a physician employed by the HMO -- a medical decision governed by state law; and whether the HMO will provide or pay for the treatment -- a plan fiduciary decision. The distinctions can become confused because, as in Respondent's case, the same individuals who make individual medical treatment decisions also may decide whether the HMO will provide or pay for a particular treatment. Notwithstanding these multiple roles, the distinctions between the discrete functions are discernible and must be recognized to avoid results like the decision below. Determining in the first instance whether a decision was a plan payment decision governed by ERISA or some other type of decision provides an analytical framework for deciding HMO cases in a manner that applies the proper regulatory scheme to HMO decisions.

A simple example is the application of a lifetime maximum benefit provision. Some plans place a dollar limit on benefits that will be paid by the plan, imposing an annual cap, for example, of \$250,000. Including this limitation in

a plan is a plan design decision that is not governed by ERISA. A physician could determine that a plan participant required treatment that exceeds the plan's dollar limits. This decision is a medical decision governed by state law. The plan's decision not to pay for the recommended treatment would be a fiduciary decision. And so long as the denial of payment was consistent with the terms of the plan, the denial would not give rise to a fiduciary breach.

Employee benefit plans that include managed care features often require the plan fiduciary to make a medical decision to determine whether the plan will pay for the benefit. *Corcoran v. United Healthcare*, 965 F.2d 1321, 1331 (5th Cir.), cert. denied, 506 U.S. 1033 (1992). Thus, in practice, the distinction among plan design, medical judgment, and payment decisions can be murky. While medical decisions made in the context of the doctor-patient relationship are governed by state law and may give rise to a tort claim under state law, medical determinations made in the context of a plan payment decision are subject to ERISA and can give rise only to a claim for benefits due under the terms of the plan. *Id.*⁵

In *Corcoran*, for example, the court distinguished among the utilization review feature (requiring advance approval for hospitalization) that the participant's employer chose to include in the employee benefit plan covering its employees, the recommendation of the participant's doctor that hospitalization was appropriate, and the medical

⁵ See *Pryzbowski v. U.S. Healthcare, Inc.*, No. 97-3097 (MTB), 1999 US Dist LEXIS 13907 (D.N.J. Sept. 8, 1999) (distinguishing between quality of medical care and quality of payment decisions; the former is governed by state law, the latter by ERISA).

judgment exercised by the plan fiduciary in determining that the plan would not pay for the hospitalization recommended by the participant's doctor. The plan fiduciary determined that the plan would not pay for the recommended hospitalization, so the participant chose a less aggressive alternative that the plan would pay for. She suffered a bad medical outcome as a result. In essence, the participant made an economic decision to elect treatment that was less desirable than the treatment recommended by her treating physician. Of course, the alternative available to her was to elect the more expensive treatment, and challenge the plan fiduciary's adverse claims decision in a later proceeding. *Id.* at 1323.

The court acknowledged that both the treating physician's recommendation of hospitalization and the plan fiduciary's decision that the plan would not pay for the hospitalization because it was unnecessary involved the exercise of medical judgment. But the court recognized that in the fiduciary's case, the exercise of medical judgment was "part and parcel of its mandate to decide what benefits are available under the . . . plan." *Id.* at 1332. Consequently, the court concluded that the participant's claim against the fiduciary for the damages arguably resulting from the claims decision was not a claim for benefits under the plan. *Id.* at 1335-38.

In the case under review, in contrast, the respondent accepted the advice of her treating physician, either because of her faith in the doctor's judgment or because of her unwillingness to bear the economic risk of obtaining an emergency sonogram that might, in the last analysis, have been unnecessary and therefore unreimbursed by the HMO. But whatever the respondent's motive in following the

recommended course of treatment, the appropriate remedy for an erroneous clinical judgment made by the treating physician is the remedy provided by state law.

"Medical necessity" requirements similarly require the plan fiduciary to make a medical decision to determine whether the plan will pay for a benefit. Many plans expressly do not pay for treatment that is not "medically necessary." Whether the determination of medical necessity is subject to ERISA depends on whether it is made by a physician determining a course of treatment for a patient or by a fiduciary deciding whether a plan will pay for a procedure.

Suppose, for example, a participant in an employee benefit plan that provides medical services through an HMO is diagnosed by an HMO doctor as having cancer. The doctor recommends a course of treatment that, in the doctor's view, is medically necessary to address the participant's condition, and rejects another, more expensive treatment that the doctor deems not to be medically necessary. This decision is a medical decision governed by state law. The doctor's decision to recommend the cheaper course of treatment that he or she thought medically necessary was based on a medical judgment, not on whether the HMO would pay for the treatment. If the doctor's recommended course of treatment is not adequate as a matter of medical judgment, the participant may have a malpractice claim against the doctor under state law.

Alternatively, the HMO doctor may recommend a course of treatment that is deemed to be not medically necessary by the HMO fiduciary that decides benefit claims ("Claim Fiduciary"). Because the benefit is not medically

necessary, the HMO will not provide or pay for the treatment. The participant has the right to appeal the Claim Fiduciary's decision and, after exhausting the HMO's administrative procedures, may bring an action in court under ERISA to obtain the benefit. This decision by the Claims Fiduciary, unlike the HMO doctor's medical necessity decision, is a plan payment decision governed by ERISA. The distinction holds true even if the HMO doctor, wearing a different hat, also is the Claims Fiduciary. *Hughes Aircraft Co. v. Jacobsen*, 119 S. Ct. at 763; *Lockheed Corp. v. Spink*, 517 U.S. at 890.

While not presented in this case, a difficult situation arises if a doctor's recommended course of treatment is appropriate, but nonetheless is a treatment that the HMO, under the terms of the plan, does not pay for. In this situation, neither the doctor nor the fiduciary has breached a duty, but the participant may be denied appropriate care if he or she can't afford to pay for the treatment outside of the HMO. While it may be tempting to blur the lines between fiduciary and non-fiduciary conduct to require an HMO to provide medical care that a participant needs, these types of *ad hoc* judgments by courts bring chaos into the system and ultimately increase the cost of benefit plans under the current regulatory schemes.

CONCLUSION

Amicus curiae Washington Legal Foundation respectfully requests the Court to reverse the decision of the Court of Appeals and to direct the dismissal of Respondent's fiduciary breach claim.

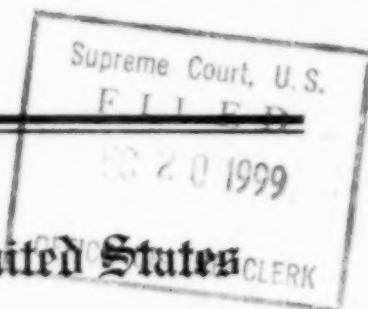
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IN THE
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Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

BRIEF OF HEALTH LAW, POLICY, AND
ETHICS SCHOLARS AS *AMICI CURIAE*
IN SUPPORT OF RESPONDENT

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF AMICI	1
SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. MANAGED CARE ORGANIZATIONS AND PHYSICIANS ARE "ERISA FIDUCIARIES" WHEN THEY (A) MAKE DECISIONS THAT DETERMINE THE COVERAGE OF AN ERISA PLAN OR (B) DELEGATE THE AUTHORITY TO MAKE SUCH DECISIONS.....	4
A. MCOs (and Physicians) Are Fiduciaries When They Exercise Discretion Over Plan Coverage Determinations	5
B. When an MCO Delegates Its Discretionary Responsibility Over Plan Coverage Determinations to Physicians, Both the MCO and the Physicians Are ERISA Fiduciaries.....	8
C. Plan Coverage Decisions and Medical Advice Are Conceptually Distinct, Even Though in an MCO Environment They Are Commonly Inseparable; Failure To Distinguish Them, and Apply ERISA to Plan Coverage Decisions, Would Be Bad ERISA Law and Bad Medicine	9
1. <i>The Plan Coverage Decision</i>	11
2. <i>The Health Care Decision</i>	13
II. THE INCENTIVE STRUCTURE AT ISSUE IN THIS CASE CREATES AT LEAST A TRIABLE ISSUE OF BREACH OF FIDUCIARY DUTY	16

TABLE OF CONTENTS—Continued

	Page
III. THE HEALTH CARE MARKET IS CONTINUOUSLY AND RAPIDLY CHANGING, AND RULES OF LAW SHOULD NOT BE FIXED FOR THE FUTURE BASED ON TODAY'S PRODUCTS	21
CONCLUSION	24
APPENDIX:	
List of Amici	1a

TABLE OF AUTHORITIES

CASES	Page
<i>Cipollone v. Liggett Group, Inc.</i> , 505 U.S. 504 (1992)	6
<i>Corcoran v. United Healthcare, Inc.</i> , 965 F.2d 1321 (5th Cir. 1992)	4, 5, 6
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TABLE OF AUTHORITIES—Continued

	Page
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STATUTES	
29 U.S.C. § 1002(21) (A)	2, 5
29 U.S.C. § 1003(1)	2
29 U.S.C. § 1004(a)	2
29 U.S.C. § 1102(a)	20
29 U.S.C. § 1102(b) (4)	20
29 U.S.C. § 1103(2)	20
29 U.S.C. § 1104(a)	7
29 U.S.C. § 1105(c)	5, 8, 9
73 Ill. Comp. Stat. 5/8-802	14
REGULATIONS	
29 C.F.R. § 2509.75-8	9
29 C.F.R. § 2560.503-1	5, 6, 20
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	Page
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**BRIEF OF HEALTH LAW, POLICY, AND
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IN SUPPORT OF RESPONDENT**

INTEREST OF AMICI

The *amici* are scholars working in the field of health care policy.¹ They are expert in such matters as the effect of financial incentives on the quality of health care, the operation of cost-containment measures developed by managed care organizations, the ethics and dynamics of the

1 The *amici* are listed in the Appendix. Pursuant to Rule 37.6 of the Rules of this Court, *amici* state that no counsel for a party authored any portion of this brief and no person or entity, other than the *amici* and their counsel, made any monetary contribution to the preparation or submission of this brief. This brief represents the views of *amici* individually and does not necessarily represent the views of institutions with which they are affiliated.

physician-patient relationship, and the workings of the present health care market. Several of the *amici* were cited in briefs in this Court.

The *amici* have prepared this brief primarily to explain (i) how decisions made by managed care organizations and doctors can, in some circumstances, constitute exercises of fiduciary duty governed by ERISA, and (ii) the consequences for patients, physicians, employers, and health benefit plans of failure to recognize the applicability of ERISA fiduciary duties in those cases to which ERISA does apply.

Counsel for the parties have consented to the filing of this brief. Copies of the consent letters have been filed with the Clerk.

SUMMARY OF ARGUMENT

ERISA fiduciary duties apply, in some circumstances, to health care related decisions made by managed care organizations (MCOs) or the physicians who are their employees and in some cases their shareholders. Specifically, employer-sponsored health benefit plans are generally "ERISA plans," *see* 29 U.S.C. §§ 1003(1), 1004(a), and any person who "has any discretionary authority or discretionary responsibility in the administration" of an ERISA plan is an ERISA fiduciary. 29 U.S.C. § 1002 (21)(A). When an ERISA plan covers "medically necessary" or "medically appropriate" (or similarly defined) health benefits, and grants an MCO the authority to determine whether particular services are within these medically defined categories, the MCO may be making ERISA plan coverage determinations at the very moment that it makes "medical necessity" health care decisions.² Such plan cov-

² This brief uses the terms "medically necessary" and "medical necessity" to refer to the plan coverage determination.

erage decisions are covered by the language and policy of ERISA.

Furthermore, the delegation of an ERISA fiduciary duty to another person is itself a fiduciary act that may not be taken disloyally or carelessly. When an MCO delegates the "medical necessity" decision to a physician, the MCO has a fiduciary duty, under ERISA, to assure that its delegate does not have an impermissible conflict of interest. A physician's substantial personal financial interest in reducing the amount expended on serving plan beneficiaries may constitute such a conflict of interest.

Failure to recognize the applicability of ERISA to the MCO's decisions in these circumstances would have at least two severe adverse consequences for the health care system. First, it would enable all concerned to immunize many negative plan coverage decisions from legal attack: if an employer plan can define coverage in terms of the broadly discretionary category "medical necessity," and if determinations of medical necessity made by MCOs and physicians are not regarded as fiduciary decisions governed by ERISA, there is no opportunity for legal review either under state law (which is broadly preempted with respect to plan coverage issues) or under ERISA—even if the doctor determining that a patient does not need a particular treatment is directly benefiting from avoiding this particular expense.

Second, a physician who has a systematic incentive to determine that particular services are not "medically necessary" within the meaning of the coverage provisions of a particular ERISA plan will have the same systematic incentive to distort her medical advice to the patient, because the plan coverage determination and the medical advice to the patient occur in the same breath. In traditional fee-for-service medicine, the physician was expected

to give medical advice essentially independent of the patient's ability to pay. Managed care plans have brought the medical advice and the payment decision together, and the real tragedy of awarding the ERISA immunity petitioners seek will be its effect on candor with which doctors advise their patients and the lack of trust this engenders. Absence of judicial oversight would be particularly troubling at a time when the market is rapidly changing.

Finally, *amici* urge the Court not to accept arguments made on the petitioner side that the only way to contain medical costs is to give physicians a clear and substantial incentive to recommend fewer and less expensive services and that no such incentives can constitute an impermissible conflict of interest or a breach of fiduciary duty. There are other means of dealing with costs (and managed-care plans have virtues besides cost-containment). Moreover, the structure of this market is evolving rapidly and that evolution should not be distorted by a broader than necessary ruling about the potential application of ERISA.

ARGUMENT

I. MANAGED CARE ORGANIZATIONS AND PHYSICIANS ARE "ERISA FIDUCIARIES" WHEN THEY (A) MAKE DECISIONS THAT DETERMINE THE COVERAGE OF AN ERISA PLAN OR (B) DELEGATE THE AUTHORITY TO MAKE SUCH DECISIONS

A managed care organization (MCO) or physician does not become an ERISA fiduciary merely by giving medical advice or providing medical services that are paid for by an ERISA plan. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356-57 (3d Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1329-34 (5th Cir. 1992). State regulation of medical practice, including state tort law, applies to such acts. However, an MCO

or physician is an ERISA fiduciary to the extent that it or she has discretionary authority to determine the coverage of the ERISA plan itself. Moreover, if an MCO has such authority and delegates it to a physician, both the MCO and the physician are ERISA fiduciaries. Any other rules would contravene both the text and the purposes of ERISA and would effectively immunize plan coverage decisions in these commonplace situations and distort the provision of medical advice.

A. MCOs (and Physicians) Are Fiduciaries When They Exercise Discretion Over Plan Coverage Determinations

A person acts as an ERISA fiduciary to the extent that it or she exercises "any discretionary authority or discretionary responsibility in the administration" of an ERISA plan, including determinations of entitlement to benefits. 29 U.S.C. § 1002(21)(A). The statute thus defines ERISA fiduciary status not merely in formalistic terms, but "in functional terms of control and authority" over the plan and benefits. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993) (citing 29 U.S.C. § 1002(21)(A)); H.R. Conf. Rep. No. 93-1280, at 323 (1974), reprinted in 1974 U.S.C.C.A.N. 5038, 5103.

Employer-sponsored ERISA health care plans often designate MCOs as fiduciaries responsible for plan administration. See, e.g., *Libby-Owens-Ford Co. v. Blue Cross and Blue Shield Mut.*, 982 F.2d 1031 (6th Cir. 1993); *Corcoran*, 956 F.2d at 1329; *Greenblatt v. Prescription Plan Servs. Corp.*, 783 F. Supp. 814 (S.D.N.Y. 1992). Insofar as these express responsibilities include discretionary determination of what services a plan covers, the MCO is an ERISA fiduciary. See 29 U.S.C. § 1105(c); 29 C.F.R. § 2560.503-1. This is true whether the MCO assigns responsibility for such determinations to adminis-

trative personnel or to physicians in its employ. Moreover, even where the MCO is not formally designated a fiduciary, it is a fiduciary under ERISA insofar as it has the practical authority to make such determinations. See 29 C.F.R. § 2560.503-1. To take a common example, if the employer's ERISA plan provides coverage for all "medically necessary" services and gives the MCO the authority to decide what is covered in a particular case, the MCO is exercising discretionary responsibility in the administration of the plan itself (*i.e.*, determining the extent of its coverage) and is an ERISA fiduciary. See *id.*; *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993). See also *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993); *Corcoran*, 965 F.2d at 1332.³

³ *Amici's* argument does not mean that state medical malpractice law is preempted. Where a single action by a physician constitutes both a clinical decision and a determination that a test or procedure is not covered by an ERISA plan, the action is potentially subject to challenge both under state law as professional negligence and substandard care (insofar as it constitutes a clinical decision) and under ERISA as a breach of fiduciary duty (insofar as it constitutes a discretionary plan coverage determination). See, *e.g.*, *Dukes*, 57 F.3d at 356-57; *In re U.S. HealthCare*, 193 F.3d 151 (3d Cir. 1999). There is nothing anomalous about this: the intertwining of clinical decisions and plan coverage determinations is an artifact of the way managed care arrangements like the one under review are structured. In a traditional fee-for-service arrangement, if a physician advised, for example, whether a tonsillectomy was necessary and an insurance company administrator determined whether a tonsillectomy was covered under an employer-sponsored insurance plan, the physician could be subject to suit under state law and the administrator under ERISA. If the two decisions are combined in a single decision made by one individual, both state and federal law may apply to different aspects of the decision. "ERISA leaves room for complementary or dual federal and state regulation . . ." *John Hancock Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993); see also *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992) (different aspects of the same cigarette advertising are governed by state and federal law).

The Solicitor General has explained that MCOs become ERISA fiduciaries to the extent that they make discretionary decisions regarding eligibility for access to services and facilities of an ERISA plan. See U.S. Br. at 26-27. The determination of "medical necessity" is of course a highly discretionary action, since different benefits administrators or physicians often reach different conclusions about appropriate diagnostic and therapeutic measures for similarly situated patients.⁴ "[A]ppraisal of medical necessity is an uncertain enterprise, fraught with ignorance about the comparative efficacy of clinical options and veiled conflict over the balancing of benefits and costs."⁵

Makers of medical plan coverage decisions owe fiduciary duties under ERISA to plan participants and beneficiaries both individually and as a group. These duties include the duty of loyalty, which requires an ERISA fiduciary to exercise its responsibility "solely in the interest of the participants and beneficiaries" and "for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." 29 U.S.C. §§ 1104(a)(1), (a)(1)(A)(i). This duty "has bite . . . it imposes . . . an obligation to act in the participants' interest." *Frahm v. Equitable Life Assurance Soc'y*, 137 F.3d 955, 959 (7th Cir.), *cert. denied*, 119 S. Ct. 155 (1998).⁶ See also *Donovan v.*

⁴ See John E. Wennberg, *Understanding Geographic Variations in Health Care Delivery*, New Eng. J. Med., Jan. 7, 1999, at 52-53; *Dartmouth Atlas of Health Care in the United States* (1998); J. Wennberg & A. Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 Science 1102-08 (1973).

⁵ M. Gregg Bloche, *Clinical Loyalties and the Social Purpose of Medicine*, JAMA, Jan. 20, 1999, Vol. 281, No. 3, p. 268, 269.

⁶ This Court has already rejected the argument by petitioners' amici (Brief of Amici Curiae American Association of Health Plans, *et al.*, in Support of Petitioners at 26) ("AAHP Br.") that ERISA's fiduciary standards protect only plans' financial integrity, not individual beneficiaries. See *Variety Corp. v. Howe*, 516 U.S. 489, 507 (1996).

Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982) (fiduciary must make all plan-related decisions "with an eye single to the interests of the participants and beneficiaries") (citations omitted); *accord Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999).

B. When an MCO Delegates Its Discretionary Responsibility Over Plan Coverage Determinations to Physicians, Both the MCO and the Physicians Are ERISA Fiduciaries

MCOs are also acting in an ERISA fiduciary capacity when they *delegate* discretionary responsibility in the administration of an ERISA plan to another person, such as a physician. 29 U.S.C. § 1105(c). In such cases, the MCO is subject to ERISA fiduciary duties both in the initial making of such delegation decisions and in continuing those delegations. *See* 29 U.S.C. §§ 1105(c)(2)(A)(i), (iii); *see also Leigh v. Engle*, 727 F.2d 113, 135 (7th Cir. 1984).⁷ ERISA applies by its terms not only to the exercise of authority over benefits determinations, but also to the delegation of such authority to others. A fiduciary's decisions about how it delegates its

⁷ In this case, petitioners themselves asserted their fiduciary status. In their memorandum opposing Herdrich's motion to remand this case to state court, they stated that Health Alliance "was the administrator and fiduciary of the Plan within the meaning of ERISA," and that Herdrich's claims against Health Alliance and Carle Clinic arose from her participation in the plan and Health Alliance's role as the fiduciary. Resp't's App. C at 24a, 36a-37a. The district court, in its order granting petitioners' motion for summary judgment based on preemption, relied on petitioners' prior representations that Health Alliance, Carle Clinic, and Carle Clinic HMO all functioned as fiduciaries. *See id.* at 9a-10a. After Herdrich amended her complaint to assert an ERISA claim, petitioners changed their tack and now insist that they cannot be subject to fiduciary liability for exactly the same alleged conduct that they had argued was shielded from state law. *See Herdrich v. Pegram*, 154 F.3d 362, 369 n.5 (7th Cir. 1998). *Compare* Resp't's App. C at 6a-10a with Pet'r's. Br. 24-26.

authority, and to whom, and under what circumstances, are themselves subject to the same duties of loyalty and prudence as other fiduciary decisions with respect to an ERISA plan. *See* 29 U.S.C. § 1105(c)(2)(A); 29 C.F.R. § 2509.75-8 at FR-13, FR-14; H.R. Conf. Rep. No. 93-1280, at 301 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5082. For example, if a fiduciary allocated discretionary authority to a person whom it knew to have an impermissible conflict of interest, the fiduciary itself could be liable for breach of its duties. *See, e.g., Leigh*, 727 F.2d at 135-36.

Petitioners argue (Br. 43-46) that an MCO's delegation of its plan administration discretion to physicians, together with the creation of a financial incentive structure that may affect the exercise of that discretion, has nothing to do with ERISA. But that cannot be right: if an MCO delegates discretionary authority to physicians to determine what services are "medically necessary" and therefore covered under an ERISA plan, and also creates a structure that rewards physicians for denying medical care, it may well have breached its duty of loyalty to the employee-beneficiaries. ERISA attaches because of the delegation, and a possible claim of fiduciary breach arises because of the incentive system. The breach is the deliberate placement of discretionary authority in individuals whose loyalty to plan beneficiaries is compromised.

C. Plan Coverage Decisions and Medical Advice Decisions Are Conceptually Distinct, Even Though in an MCO Environment They Are Commonly Inseparable; Failure To Distinguish Them, and Apply ERISA to Plan Coverage Decisions, Would Be Bad ERISA Law and Bad Medicine

In traditional fee-for-service medicine, health care decisions and payment decisions were in principle separate

matters. The physician giving health care advice was expected to consider only the best interests of the patient. How the patient would pay for the recommended services was a distinct question: he might do so through personal resources, or through insurance, or through an employer health plan. The service also might be "financed" through the physician's own charity, but physicians were of course not obligated to provide services without charge merely because they recommended them.

Two features of this traditional system are pertinent to the present case. First, the medical advice and any "plan coverage" decision were distinct. Patients and physicians assumed that the physician's advice about the medical desirability of a particular service did not depend on whether the patient could afford it or his employer's plan covered it. Second, whoever made the plan coverage decision was an ERISA fiduciary.

Under many current ERISA plan arrangements, including the arrangement at issue in this case, the health care decision and the coverage decision—though conceptually distinct—have become one decision. The employer adopts a health plan that offers care by an MCO. The extent of care provided under the plan is defined by terms like all "medically necessary" or "medically appropriate" services. The plan then provides that the determination of "medical necessity" (or "appropriateness") will be made by the MCO itself. The MCO may in turn, like the MCO in this case, delegate that responsibility to the individual physicians.

In such a case, it is very important, for two quite different reasons, to maintain the conceptual distinction between the health care decisions and the plan coverage decisions, and to hold the MCO and the physicians to

ERISA fiduciary standards with respect to the latter.⁸ Petitioners' effort to immunize the plan coverage decision from ERISA (or any other) liability is both bad law and bad medicine.

1. *The Plan Coverage Decision*

Failure to recognize the dual role played by gatekeeper physicians effectively immunizes an important category of plan administrative decisions from any legal review whatever. The person who decides whether a particular employer health plan, applied to a particular patient in particular circumstances, covers a particular diagnostic test or procedure (or covers a swifter or more sophisti-

⁸ When a physician who is responsible for the patient's care also makes gatekeeping and "medical necessity" determinations, he necessarily makes some decisions that constitute both the practice of medicine and, under ERISA, the discretionary administration of plan benefits. In the former role, the physician is subject to professional standards and state regulation but is not an ERISA fiduciary. See, e.g., *Dukes v. U.S. HealthCare, Inc.*, 57 F.3d 350, 356-57 (3d Cir. 1995). However, when the physician exercises discretion with respect to plan administration by, for example, interpreting plan provisions, denying claims, and determining access to benefits and services promised under the plan, he is an ERISA fiduciary and is subject to liability under ERISA's fiduciary duty provisions. See *id.* See also *In re U.S. HealthCare*, 193 F.3d 151 (3d Cir. 1999); *Pryzbowski v. U.S. HealthCare, Inc.*, 64 F. Supp. 2d 361 (D.N.J. 1999); *Huss v. Green Spring Health Servs.*, 18 F. Supp. 2d 400 (D. Del. 1998); *Moreno v. Health Partners Health Plan*, 4 F. Supp. 2d 888, 892 (D. Ariz. 1998); *Edelen v. Osterman*, 943 F. Supp. 75, 76-77 (D.D.C. 1996). Different MCOs employ different combinations of centralized administrative review and contractual delegation of benefits decisions to gatekeeping clinicians. These two mechanisms are alternative means of performing the same function—administration of health benefits pursuant to the open-ended contractual standard of medical necessity. Robert A. Berenson, *A Physician's View of Managed Care*, 10 *Health Affairs* 106 (1991). Centralized administrative review and physician gatekeeping in the clinic and at the bedside are thus both fiduciary functions under ERISA.

cated approach than might be warranted under other circumstances) is acting as an administrator of the ERISA plan, but his actions, according to petitioners, fall into a legal limbo. He is not liable under state law because his actions constitute the interpretation of an ERISA plan, not the practice of medicine, and state law is therefore preempted. The MCO also cannot be held liable under state law for decisions interpreting an ERISA plan, or for the manner in which it delegated responsibility for such decisions. But, according to petitioners, the physician and the MCO cannot be held liable under federal law either, because the decision whether a particular test or procedure was "medically necessary" is a medical decision, not an ERISA decision.⁹

One obvious consequence of this view of the law would be to distort the structure of the provision of medical services. The desire of employers, MCOs, and physicians all to escape legal responsibility for the interpretation of the benefits provisions of ERISA plans would create a strong incentive to establish arrangements in which benefits provisions are effectively subsumed within the term "medically necessary" and the highly discretionary decision as to what is medically necessary is immunized from state law liability as an ERISA decision and from federal law liability as a medical decision.

The irony is that the decisions at issue are exactly the sort to which fiduciary standards are traditionally thought to apply. The determination of what tests or treatment is appropriate for a particular patient in a particular situation is an inherently discretionary decision—*i.e.*, one for which the relevant parties, the employee-patient, the em-

⁹ Both halves of this are wrong. The decision is subject to state law as a medical decision and to ERISA as a plan coverage decision. See *supra* note 3.

ployer, the MCO, and the physician, *cannot* satisfactorily provide in advance by contract, no matter how detailed a contract they try to write.¹⁰ That is precisely the kind of situation in which the traditional solution is to hold the persons who will make the discretionary decisions to a fiduciary standard of responsibility.¹¹ The potential for self-serving in the making of discretionary decisions is a central problem in health care economics precisely because contracts for medical care and coverage are necessarily incomplete—they cannot avoid conferring great discretion on physicians and other administrators to determine medical necessity¹²—and because purchasers of medical care and coverage (those with the incentive to detect misappropriation) know less about diagnosis and treatment of disease than do physicians.¹³

2. The Health Care Decision

Allowing ERISA plan coverage decisions to be immunized from liability by coupling them with health care decisions under the blanket of "medical necessity" also has

¹⁰ See generally Oliver E. Williamson, *Transaction Cost Economics: The Governance of Contractual Relations*, 22 J.L. & Econ. 233 (1979) (arguing that in contractual situations in which all possibilities cannot be anticipated, one needs to develop workable governance mechanisms to address ongoing uncertainty in order to instill trust on the part of the parties).

¹¹ See Tamar Frankel, *Fiduciary Law*, 71 Cal. L. Rev. 795 (1983); Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. Rev. 1045 (1991).

¹² In his dissent below (on petition for rehearing), Judge Easterbrook acknowledges that "[f]iduciary duties are vital when contracts are incomplete," 170 F.3d at 686, but he then ignores the discretionary nature of medical care contracts when he claims that there is no question about whether the contract here was incomplete.

¹³ Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941 (1963).

an even more serious consequence: it creates a strong incentive for the physician to distort his health care advice to his patient. If the physician has a personal economic incentive to deny ERISA plan coverage, and his vehicle for doing so is a discretionary determination that a particular test or procedure is not "medically necessary," there is an obvious risk that the patient will be denied not only the economic benefit promised by the plan, but candid health advice.

Patients' expectations when they seek medical care derive from the 2500 year old Hippocratic ethic of physician loyalty to patients. This ideal is deeply embedded in both patients' understanding¹⁴ and the law applicable to medicine.¹⁵ Moreover, as explained in a now-classic article by Nobel laureate economist Kenneth Arrow, this ethic is essential if patients are to trust medical judgment and such trust is in turn essential to the operation of health care systems because most patients lack the medical knowledge to evaluate physicians' recommendations.¹⁶ There is a large body of scholarly commentary to the effect that patient trust and physician trustworthiness make diag-

¹⁴ See Talcot Parsons, *The Social System* 428-447 (1951). "As late as 1969, the philosopher Hans Jonas could assert that 'the physician is obligated to the patient and to no one else. . . . We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.'" David J. Rothman, *Strangers at the Bedside* 1 (1991) (internal citation omitted).

¹⁵ See, e.g., 73 Ill. Comp. Stat. 5/8-802 (Illinois evidence statute provides testimonial privilege for physician-patient communications); *State v. Perry*, 610 So. 2d 746, 751-53, 769 (La. 1992) (relying on ethical duty to act only for patient's well-being in holding that involuntary medication to render inmate competent for execution violated state constitutional proscription of cruel and unusual punishment).

¹⁶ Arrow, *supra* note 13.

nosis and treatment more effective¹⁷ and enable the sick to take comfort and draw strength from their doctors during their most anxious and fearful moments.¹⁸ Arrangements that create incentives for physicians to declare tests or procedures not "medically necessary" in order to save the cost of providing them have the potential to compromise that trust and should be subject to review under ERISA to determine whether they are permissible.¹⁹

Because patients typically form deeper, more enduring relationships with their primary care physicians than with other health care providers, the dual loyalties of "gatekeeping" primary caretakers are especially troublesome:

The more powerful the message of fidelity conveyed within a clinical relationship, the more compelling a social purpose should be to justify departure from the

¹⁷ See, e.g., David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 Milbank Q. 171, 176 (1996); David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. Health Pol., Pol'y & L. 661 (Aug. 1998); Marc A. Rodwin, *Medicine, Money and Morals: Physicians' Conflicts of Interest* (1993); Arthur L. Caplan, *Am I My Brother's Keeper?: The Ethical Frontiers of Biomedicine* (1998); Arnold Relman, *The Impact of Market Forces on the Physician-Patient Relationship*, J. Royal Soc'y Med. 1994; 87 Supp. 22: 22-4.

¹⁸ E.g., Jay Katz, *The Silent World of Doctor and Patient* (1984).

¹⁹ There is also, of course, a disclosure problem. When physicians are acting in a dual role, as both medical caregivers and benefits gatekeepers, their patients may not be aware of both roles. Absent clear communication from a health plan to its subscribers that plan physicians will not be held to the Hippocratic ethic of loyalty to patients, and indeed will be encouraged to depart from it for the sake of frugal stewardship of plan resources, subscribers are entitled to expect their physicians to adhere to this ethic—and to expect the plan to administer benefits in a manner that does not suborn its breach. A health plan's promise of "medically necessary" treatment does not even hint at the scheme of dual clinical loyalties introduced by financial incentives to gatekeeping physicians to withhold plan benefits.

ethic of undivided loyalty. Health plans that make primary care physicians into gatekeepers, with strong incentives to deny access to beneficial care, pose a special problem in this regard.

* * * *

These concerns bear greatly on the legal controversies that have marked the rise of managed care. . . . [T]hey merit judicial recognition of professional duties of loyalty and patient advocacy vis-a-vis health plans.²⁰

The loss of patient-physician trust is of course not the direct concern of ERISA, but it is a consequence of misinterpreting ERISA. Medical advice and health plan coverage are both inherently discretionary functions. It is not necessarily wrong to combine them and apply a standard of "medical necessity" to both. What is essential is to remember that the combined decision contains a plan determination decision, and if an MCO creates a structure (particularly a structure not necessarily disclosed to patients) that gives physicians a strong personal economic incentive to make one decision rather than another, that structure must be subject to testing under ERISA fiduciary standards.

II. THE INCENTIVE STRUCTURE AT ISSUE IN THIS CASE CREATES AT LEAST A TRIABLE ISSUE OF BREACH OF FIDUCIARY DUTY

This case is in this Court following the defendants' successful motion to dismiss for failure to state a claim. Whether the plaintiff will be able to prove her claim is not at issue at this point, and *amici* take no position on that question. The incentive structure described in the complaint, however, clearly creates a triable issue as to

whether the defendants have breached their fiduciary duty.

As described in the complaint, the structure created by the defendants (i) delegates to physicians the authority to make certain health care related decisions and, at the same time, (ii) gives the same physicians a substantial financial incentive, in the form of year-end cash distributions, for minimizing the use of diagnostic tests, facilities not owned indirectly by the MCO, and referrals to independent physicians. Although the complaint is not artfully pleaded, it appears to make out a claim that the MCO has delegated its ERISA fiduciary responsibility for determining the tests and other services available to an employee-patient, such as respondent, to physicians to whom the MCO has itself offered a financial incentive that is inconsistent with the ERISA duty of loyalty to the employee. If these allegations are correct, the MCO may have violated ERISA fiduciary duties by delegating them to persons with a clear and substantial conflict of interest, and the physicians may have violated ERISA fiduciary duties by exercising such responsibilities despite the conflict. Respondent should be given an opportunity to prove that claim.

Amici are not suggesting that either health care decisions or plan coverage decisions can—or even that they should—always be made without consideration of cost and without any economic incentive influencing the physician. The problem of how to contain health care costs is real, and *amici* support ongoing creative efforts to solve it in ways that are fair to employee-patients. But there is a difference between general, widely shared, structural incentives to cut costs and an incentive that is so pointed and substantial that it would plausibly influence the "medical necessity" judgment in an individual case.

²⁰ Bloche, *supra* note 5, at 273.

Petitioners argue (Br. 46-47) that some conflicts of interest are inevitable in any method of providing and financing health care.²¹ For example, Judge Easterbrook's dissent below noted (170 F.3d at 684) that in traditional fee-for-service medicine the physicians had an incentive to recommend marginal or unneeded services in hopes of earning a fee. But such abuses were, in principle, subject to challenge as malpractice. The kind of incentive alleged in this case, where the "gatekeeper" physician assertedly received economic benefits specifically tied to decisions of the kind at issue—is inconsistent with the duty of loyalty imposed by ERISA.

Petitioners also argue (Br. 39-40) that physician economic participation is essential to effective cost-containment,²² but that is not true. Risk-sharing incentives are

²¹ Petitioners also contend that ERISA allows a single entity to have "dual loyalties" and that ERISA's fiduciary duties do not preclude decisionmaking based on business factors. Br. 43-45. But Petitioners rely on a series of cases dealing solely with the role of employers in establishing and designing benefit plans. See, e.g., *Hughes Aircraft Co. v. Jacobsen*, 525 U.S. 432 (1999). *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73 (1995). These cases are inapposite because the "dual loyalties" permitted to employers do not come into play here. Recognizing that employers necessarily consider business factors when making basic decisions regarding plan establishment and design, this Court has held that ERISA's fiduciary duty provisions do not apply to employer decisions to establish, amend or terminate plans. See *Hughes Aircraft Co.*, 525 U.S. 432; *Lockheed*, 517 U.S. at 893-94; *Curtiss-Wright*, 514 U.S. 73. Here, the relevant employer, State Farm (which is not a defendant), established the ERISA plan in this case, and petitioners cannot rely on the special allowance for employers' dual loyalties. Moreover, the "dual loyalties" cases do not exempt employers from potential ERISA fiduciary liability for conflicts of interest. See, e.g., *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

²² See also AAHP Br. 3, 8, 17.

only one of many ways MCOs achieve their savings. Network development, management and coordination of practice, review of whether physicians are making appropriate decisions and referrals, the integration of group practices, and other techniques of managed care also reduce costs.²³ MCOs are developing more sophisticated physician compensation methods to incorporate measures of quality, patient satisfaction, and efficiency (achieving the same result at less cost), rather than simply reward reduced costs.²⁴ Thus, MCOs will have a variety of means to control their spending even if limits are placed on the use of some kinds of physician risk-sharing incentives.

The reason why MCOs create financial incentives for physicians to reduce levels and expenses of service is that they do indeed reduce costs. But they achieve this by inducing physicians to make intertwined coverage and health care decisions different from those they would make if their only concern were the employee-patient. As Judge Easterbrook noted, "The HMO structure differs substantially from traditional fee-for-service medicine in giving the HMO an incentive to skimp on care once an illness is discovered." 170 F.3d at 684.

The very purpose of ERISA is to assure that persons making discretionary benefits decisions act under a duty of loyalty to the beneficiary. See H.R. Conf. Rep. No. 93-1280, at 297, reprinted in 1974 U.S.C.C.A.N. at 5078 (the

²³ Development of provider networks both empowers health plans to win price concessions from providers and creates incentives for providers to conform their clinical practice styles to network norms (in order to sustain or increase flows of patients). Ching-to Albert Ma & Thomas G. McGuire, *Network Incentives in Managed Health Care* (Oct. 1999) (unpublished paper on file at the Boston University Dep't of Economics).

²⁴ Neil Schlackman, *Evolution of a Quality-Based Compensation Model: The Third Generation*, 8 Am. J. Med. Quality 103 (1993).

written plan must identify the named fiduciary with ultimate authority over and liability for plan administration, including the making of payments from the plan).²⁵ The statute was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983) (citations omitted); accord *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989). It protects employee and beneficiary interests "by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access to the Federal courts." *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996) (quoting ERISA § 2(b)) (alterations in original). This Court has said that Congress expected the courts to interpret ERISA's fiduciary standards "bearing in mind the special nature and purpose of employee benefit plans." *Id.* at 497 (citation omitted). See also *Firestone Tire & Rubber Co.*, 489 U.S. at 113-14. Contrary to petitioners' suggestion (Br. 34) that ERISA narrowed the scope of traditional fiduciary obligations, Congress determined that the common law of trusts did not offer enough protections. See *Varity*, 516 U.S. at 497; H.R. Conf. Rep. No. 93-1280, at 295, 302 (1974), reprinted in 1974 U.S.C.C.A.N. 5038, 4650. This Court should not accept petitioners' invitation to immunize an important mechanism for determining the coverage of an ERISA health-care plan from review under ERISA fiduciary standards.

²⁵ See also 29 U.S.C. § 1103(2) ("appropriate named fiduciary" must be in charge of final benefits claims decisions); *id.* § 1102(a) (each plan must specify its named fiduciaries in writing); *id.* § 1102(b)(4) (each plan must specify in writing the method for making payments out of the plan); 29 C.F.R. § 2560.503-1(g) (appeals of benefit denials must be made to a named fiduciary).

III. THE HEALTH CARE MARKET IS CONTINUOUSLY AND RAPIDLY CHANGING, AND RULES OF LAW SHOULD NOT BE FIXED FOR THE FUTURE BASED ON TODAY'S PRODUCTS

Neither the majority nor the dissent in the court below correctly described the role of financial incentives in managed care and cost-containment or the effect of financial incentives on physician behavior. If the Court considers the implications of such incentives in health policy in analyzing the legal issues in this case it should do so on a sound basis:

Many policies that give physicians incentives to withhold services originate from private institutions and government agencies as responses to the distortions of fee-for-service medical practice. A simple syllogism has governed policy: giving physicians incentives to perform services produces undesirable effects. Ergo, eliminate these problems by giving physicians incentives to refrain from performing services. Only one thing was overlooked: rewarding physicians for using resources frugally does not eliminate financial conflicts of interest. It creates new conflicts with different effects.²⁶

Physicians have generally been compensated for their work and thus financial incentives have always been part of health care. Until early in the 20th century most doctors, hospitals, and other medical providers were paid a fee for each service they provided, except when providing charity care. This form of payment encouraged doctors to increase the services provided. Starting in the 1930s, experiments with prepaid group practice, a precursor of HMOs, paid doctors a salary in part to counter the per-

²⁶ Rodwin, *supra* note 17, at 135 (internal citations omitted).

verse effect of fee-for-service payment, in part to reduce the cost of providing medical care. Pre-paid group practice and HMOs that paid physicians a salary reduced the performance of unnecessary services, particularly surgery, and cut health care spending.²⁷ More recently, MCOs have introduced newer forms of incentives including physician risk-sharing. Risk-sharing is achieved by paying physicians per capita for providing all services necessary to a particular patient and through a wide array of financial reductions and bonuses. A common feature of risk-sharing is that it makes doctors bear some of the financial cost for the services they themselves provide; more recent risk-sharing models make doctors financially responsible also for the services they recommend or order through referrals, tests, or use of hospitals.

The aim of risk-sharing incentives for physicians under managed care is undisputed: to make physicians consider the financial implications of the clinical choices they make. In using this approach MCOs hope to enlist physician help in controlling health care spending. Quite explicitly, risk-sharing incentives ask doctors to consider their own financial interest in making diagnoses, choosing what tests or medications to prescribe and evaluating competing treatments. MCOs use such incentives because the discretionary judgments of doctors in providing patient care have an enormous influence on resource use and thus affect the financial status of organizations that contract to provide services for a set premium.

Although benefit packages for MCO and indemnity insurance typically exclude a few benefits, they generally state that they will cover all medical care that is "medically necessary" or "medically appropriate." As discussed

²⁷ See generally David Mechanic, *From Advocacy to Allocation: The Evolving American Health Care System* (1986).

above in Section I.C.1., such terms are not clearly defined in contracts (and cannot be because medical standards change). Like legal principles, terms like "medical necessity" must be applied to facts to yield specific results. It is doctors who make such determinations on a case-by-case basis, and it is to influence such decisions with the hope of preserving resources for the organization or its owners that doctors are given financial incentives.

A substantial body of research demonstrates that fee-for-service payment of physicians correlates closely with higher utilization of hospital and other clinical services and that capitation and other incentives to withhold care correlate closely with lower utilization.²⁸ It is not known at what point such incentives lead to undertreatment of patients or whether or to what extent MCO quality assurance programs can ensure quality and prevent undertreatment, but there is reason to be concerned that such incentives will produce effects at least as perverse as fee-for-service payment.²⁹

Managed care does have several desirable goals independent of containing medical costs, including promoting the use of evidence-based medicine, improving medical care, and coordinating medical services more rationally. Limits on physician incentives that MCOs use might affect the way managed care is practiced today, but the managed care of today is quite different from the managed care of a decade and a half ago and the managed care of tomorrow will be different again. Managed care is not now and has never been one distinct idea or method but rather a variety of approaches to managing medical care. And it

²⁸ See Thomas Rice, *Physician Payment Policies: Impacts and Implications*, 18 Ann. Rev. Pub. Health 549 (1997).

²⁹ See Norman Daniels & James Sabin, *Accountability for Reasonableness, Professionalism, and the Ethics of Physician Incentives* (unpublished paper on file at the Tufts University Dep't of Philosophy).

is rapidly changing in response to markets, legislation, and the intervention of private and public payers of medical services that are setting constraints on how managed care operates. The Court has been invited by the opinions below to legislate bright-line rules about fiduciary status and fiduciary breaches under managed care. The Court need not draw bright lines excluding all cost-containment measures and all physician decision-making from judicial review in order to preserve the ability to control health care costs.

CONCLUSION

The judgment of the Court of Appeals for the Seventh Circuit should be affirmed.

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Supreme Court, U.S.

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OFFICE OF THE CLERK

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

On Writ Of Certiorari To The United States
Court Of Appeals For The Seventh Circuit

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AMERICAN PSYCHIATRIC ASSOCIATION, CENTER
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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iv
INTEREST OF <i>AMICI CURIAE</i>	1
SUMMARY OF THE ARGUMENT	1
ARGUMENT	2
I. CONGRESS HAS NEVER AUTHORIZED THE EXEMPTION OF MANAGED-CARE ORGANI- ZATIONS FROM LEGAL OVERSIGHT	2
A. Congress Designed ERISA To Protect Bene- ficiaries From Abuses By Those Who Administer And Control Employee Welfare Plans, Irrespective Of The Form Of Such Plans	3
1. The majority of Americans receive their health insurance through employer-spon- sored managed-care health plans	3
2. ERISA was designed to protect benefici- aries from abuses by those who admin- ister employee welfare plans	5
B. Federal Laws Supporting The Growth Of Managed Care Do Not Establish Any Con- gressional Intent To Immunize Managed- Care Organizations From Legal Accoun- tability	6
1. The federal Health Maintenance Organi- zation Act does not exempt managed- care organizations from ERISA or any other source of legal oversight	6
2. The managed-care provisions of the Social Security Act demonstrate Con- gress' intent to protect beneficiaries while encouraging the growth of quality managed care	7

TABLE OF CONTENTS – Continued

	Page
II. WHERE CLAIMS PERTAINING TO THE CREATION OF A FINANCIAL INCENTIVE SCHEME HAVE BEEN HELD PREEMPTED BY ERISA, THEY MUST BE FOUND TO CONCERN THE ACTIONS OF A FIDUCIARY UNDER ERISA	10
A. The Concept Of A Fiduciary Under ERISA Must Be Understood In Light Of The Statute's Goals And Its Relationship To State Law	10
B. Petitioners' Untenable And Unprecedented Goal – Immunity From Both State And Federal Oversight For Their Alleged Breaches – Should Be Rejected By This Court As An Improper Effort To Manipulate ERISA Preemption	11
C. A Party's Status As A Fiduciary Under ERISA Turns On Its Function Rather Than Its Form	14
III. ALLEGATIONS THAT A FIDUCIARY ESTABLISHED AN INCENTIVE SCHEME TO BENEFIT THE FIDUCIARY'S PRINCIPALS BY DISCOURAGING PROVISION OF CARE STATE A COGNIZABLE CLAIM FOR BREACH OF FIDUCIARY DUTY UNDER ERISA	20
A. An ERISA Fiduciary's Sole Obligation, With Or Without Dual Loyalties, Is To Act In The Interests Of The Beneficiaries	20
B. When Acting In The Fiduciary Role, Plan Administrators Are Not Free To Ignore Their Conflict Of Interest But Must Seek To Bring Their Conflicting Interests To A Resolution Consistent With ERISA's Goals	24

TABLE OF CONTENTS – Continued

	Page
C. Courts Are Well-Equipped To Review Allegations Of Breach Of Trust By Administrators Of Managed-Care Plans	26
D. Preservation Of A Cause Of Action For Breach Of Fiduciary Duty In A Managed-Care Setting Will Neither Threaten The Viability Of Managed Care Nor Open The Floodgates To Litigation	28
CONCLUSION	30
APPENDIX A	App. 1

TABLE OF AUTHORITIES

Page

CASES

<i>Alessi v. Raybestos Manhattan, Inc.</i> , 451 U.S. 504 (1981)	26
<i>Amato v. Western Union Int'l, Inc.</i> , 773 F.2d 1402 (2d Cir. 1985), <i>cert. dismissed</i> , 474 U.S. 1113 (1986)	15
<i>American Fed'n of Unions v. Equitable Life Assurance Soc'y</i> , 841 F.2d 658 (5th Cir. 1988)	18
<i>Andrews-Clarke v. Travelers Ins. Co.</i> , 984 F. Supp. 49 (D. Mass. 1997)	10, 12
<i>Bailey v. Blue Cross & Blue Shield of Virginia</i> , 67 F.3d 53 (4th Cir. 1995), <i>cert. denied</i> , 516 U.S. 1159 (1996)	18
<i>Boggs v. Boggs</i> , 520 U.S. 833 (1997)	3, 5
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<i>Chambers v. Family Health Plan Corp.</i> , 100 F.3d 818 (10th Cir. 1996)	25
<i>Conley v. Gibson</i> , 355 U.S. 41 (1957)	26
<i>Corcoran v. United HealthCare, Inc.</i> , 965 F.2d 1321 (5th Cir.), <i>cert. denied</i> , 506 U.S. 1033 (1992)	4, 12, 13, 19
<i>Coyne & Delany Co. v. Selman</i> , 98 F.3d 1457 (4th Cir. 1996)	15
<i>Curcio v. John Hancock Mut. Life Ins. Co.</i> , 33 F.3d 226 (3d Cir. 1994)	15
<i>Davis v. Wakelee</i> , 156 U.S. 680 (1895)	12
<i>Doe v. Group Hospitalization Medical Servs.</i> , 3 F.3d 80 (4th Cir. 1993)	25

TABLE OF AUTHORITIES - Continued

Page

<i>Donovan v. Bierwirth</i> , 680 F.2d 263 (2d Cir. 1982)	23, 29
<i>Drolet v. Healthsource, Inc.</i> , 968 F. Supp. 757 (D.N.H. 1997)	16, 18, 19
<i>Dukes v. U.S. Healthcare, Inc.</i> , 57 F.3d 350 (3d Cir.), <i>cert. denied</i> , 516 U.S. 1009 (1995)	4, 13
<i>Firestone Tire and Rubber Co. v. Bruch</i> , 489 U.S. 101 (1989)	5, 21
<i>Florence Nightingale Nursing Serv. v. Blue Cross & Blue Shield of Alabama</i> , 41 F.3d 1476 (11th Cir.), <i>cert. denied</i> , 514 U.S. 1128 (1995)	18
<i>Fort Halifax Packing Co. v. Coyne</i> , 482 U.S. 1 (1987)	17
<i>Fuja v. Benefit Trust Life Insurance Co.</i> , 18 F.3d 1405 (7th Cir. 1994)	23
<i>Herdrich v. Pegram</i> , 154 F.3d 362 (7th Cir. 1998), <i>rehearing en banc denied</i> , 170 F.3d 683 (1999)	11, 12, 15, 17
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<i>Hughes Aircraft Co. v. Jacobson</i> , 525 U.S. 432, 119 S.Ct. 755 (1999)	24
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<i>Johnson v. Flowers Indus.</i> , 814 F.2d 978 (4th Cir. 1987)	19
<i>Joyce v. RJR Nabisco Holdings Corp.</i> , 126 F.3d 166 (3d Cir. 1997)	13
<i>Leigh v. Engle</i> , 858 F.2d 361 (7th Cir. 1988)	23

TABLE OF AUTHORITIES – Continued

Page

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<i>Massachusetts Mutual Life Ins. Co. v. Russell</i> , 473 U.S. 134 (1985)	5, 29
<i>Meinhard v. Salmon</i> , 249 N.Y. 458, 164 N.E. 545 (1928)	22
<i>Mertens v. Hewitt Associates</i> , 508 U.S. 248 (1993)	11, 15, 25, 26
<i>Morales v. Health Plus, Inc.</i> , 954 F. Supp. 464 (D.P.R. 1997)	19
<i>Nachman Corp. v. Pension Benefit Guaranty Corp.</i> , 446 U.S. 359 (1980)	5
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<i>O'Reilly v. Ceuleers</i> , 912 F.2d 1383 (11th Cir. 1990) ...	16, 19
<i>Pacificare, Inc. v. Martin</i> , 34 F.3d 834 (9th Cir. 1994)	18
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TABLE OF AUTHORITIES – Continued

Page

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STATUTES AND REGULATIONS	
Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251	8
Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.	passim
ERISA § 3(21)(A)	14
29 U.S.C. § 1001(a)(1)	21
29 U.S.C. § 1001(b)	5
29 U.S.C. § 1002(1)	3, 19
29 U.S.C. § 1002(21)(A)	15, 17
29 U.S.C. § 1054-56	20

TABLE OF AUTHORITIES – Continued

	Page
29 U.S.C. § 1081	20
29 U.S.C. § 1101(a)	21
29 U.S.C. § 1104(a)(1)	23
29 U.S.C. § 1106(a)(1)(d)	21
29 U.S.C. § 1132(a)	5
29 U.S.C. § 1132(a)(2)	29
29 U.S.C. § 1144(a)	10
29 U.S.C. § 1144(b)(2)(A)	10
29 U.S.C. § 1144(b)(2)(B)	10
29 U.S.C. § 1221-22	20
Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e <i>et seq.</i>	6
42 U.S.C. § 300e(c)(1)	7
42 U.S.C. § 300e(c)(5)	7
42 U.S.C. § 300e-4	7
42 U.S.C. § 300e-4(d)	7
42 U.S.C. § 300e-9	7
42 U.S.C. § 300e-9(d)	7
42 U.S.C. § 1395b(m)(4)(A)	9
42 U.S.C. § 1395mm(b)	8
42 U.S.C. § 1395mm(b)(2)	8
42 U.S.C. § 1395mm(c)	8
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TABLE OF AUTHORITIES – Continued

	Page
42 U.S.C. § 1395w-21(a)(2)(A)	8
42 U.S.C. § 1395w-21(e)	8
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42 U.S.C. § 1395w-22(e)	8
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42 U.S.C. § 1395w-22(g)	8
42 U.S.C. § 1395w-22(j)(3)	9
42 U.S.C. § 1395w-22(j)(4)	8
42 U.S.C. § 1395w-22(j)(4)(i)	9
42 U.S.C. § 1395w-22(j)(4)(ii)(I)	9
42 U.S.C. § 1395w-22(j)(4)(ii)(II)	9
42 U.S.C. § 1396b(m)	8
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TABLE OF AUTHORITIES – Continued

Page

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TABLE OF AUTHORITIES – Continued

Page

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INTEREST OF AMICI CURIAE

The *amici curiae* joining this brief are non-profit organizations representing health care users and providers, each of which has worked at the state or federal level to help ensure that individuals can obtain the health care that they need. These organizations, which serve a wide geographic area, include: Health Care For All (Massachusetts), the American Psychiatric Association, The Center for Health Care Rights (California), Community Catalyst, Connecticut Citizen Action Group, Consumers for Affordable Health Care Foundation (Maine), Greater Upstate Law Project (New York), Health Administration Responsibility Project (California), National Health Law Program, New Hampshire Citizens Alliance, Northwest Health Care Advocates (Washington), Public Interest Law Center (New Jersey), Texas Citizen Fund, Texas Heart.

Each of these organizations has either represented individuals or engaged in advocacy on behalf of patients of managed-care organizations.¹ These patient and provider groups have joined together because they each believe that the resolution of the issues raised by this case is critical to ensuring that patients in managed-care organizations are able to access meaningfully the health care benefits which they have been promised. A more complete description of each organization signing this brief is provided in Appendix A.

SUMMARY OF THE ARGUMENT

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"), was designed to protect beneficiaries of employee welfare plans from abuses by plan fiduciaries. Congress has never suggested

¹ Counsel for the *amici curiae* authored this brief in its entirety. No person or entity, other than the *amici curiae*, their members or counsel, made a monetary contribution to the preparation or submission of this brief. Letters of consent from the parties have been filed with the Clerk of this Court.

that ERISA's protections do not apply to the millions of Americans who rely on employer-provided managed-care health plans.

The determination of whether a health insurance company that contracts with an ERISA plan is a fiduciary must be made in light of ERISA's multiple goals of protecting beneficiaries, encouraging the establishment of health care plans, and respecting the norms of federalism. Petitioners' untenable and unprecedented goal – immunity from both state and federal law for their alleged breaches – is an improper effort to manipulate ERISA preemption. Where a defendant that controls access to benefits under an ERISA plan has successfully moved to preempt state law claims, that defendant is subject to ERISA's fiduciary obligations.

The allegation that an ERISA fiduciary has established an incentive system that profits the fiduciary's principals by discouraging the provision of benefits promised under the plan states a cause of action cognizable under ERISA. An ERISA fiduciary's sole obligation, whether or not faced with dual loyalties, is to act in the interests of the beneficiaries. When acting as such, a fiduciary must seek to bring its conflicting interests to a resolution consistent with ERISA's goals. Placing such an obligation on managed-care entities will neither threaten the viability of managed care nor open the floodgates to litigation. Rather, it will simply ensure that the beneficiaries of managed-care health benefit plans established under ERISA have the same rights Congress granted to all ERISA plan beneficiaries.

ARGUMENT

I. CONGRESS HAS NEVER AUTHORIZED THE EXEMPTION OF MANAGED-CARE ORGANIZATIONS FROM LEGAL OVERSIGHT.

This case arises at the intersection of ERISA and managed-care policies. When ERISA was enacted, managed care, as a form of health insurance, was relatively

rare. See Rand E. Rosenblatt et al., *Law and the American Health Care System* 543-44 (1997). Since the 1980s, managed care has grown dramatically. See *id.* at 544 (by 1995, 78 percent of all privately insured persons were enrolled in managed-care plans). Despite this growth, there is neither authority nor reason to conclude that Congress intended to exempt managed-care plans from both ERISA's own protections and available state law protections. To the contrary, ERISA's text, 29 U.S.C. § 1002(1) (clarifying that health plans are welfare plans under ERISA), as well as its joint goals of encouraging employers to offer benefit plans and protecting beneficiaries, require that settled principles of federalism and fiduciary obligation apply to entities that oversee employee managed-care health plans. See *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996) (discussing ERISA's fiduciary obligations); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995) (discussing the application of federalism to ERISA). These principles establish that the administrators of managed-care organizations ("MCOs") must be accountable under state law or ERISA itself.

A. Congress Designed ERISA To Protect Beneficiaries From Abuses By Those Who Administer And Control Employee Welfare Plans, Irrespective Of The Form Of Such Plans.

1. The majority of Americans receive their health insurance through employer-sponsored managed-care health plans.

This Court has noted the "centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997). Indeed, employer-sponsored health coverage is critical to a majority of Americans. In 1997, 151.7 million Americans received their health insurance through an employer-provided

plan. Robert Kuttner, *Health Policy Report: The American Health Care System: Employer-Sponsored Health Coverage*, 340 New Eng. J. Med. 248, 248 (1999). Obviously, ERISA's impact on the ability of beneficiaries to redress grievances against such plans is of critical importance.

Until the early 1980s, most employer-sponsored health plans provided "indemnity" coverage, in which insurance companies (or the employer plan itself) paid for medical care on a fee-for-service basis, without involving themselves in delivering or managing the care. See Rand E. Rosenblatt et al., *Law and the American Health Care System* 543 (1997). In the last two decades, largely in response to the rising costs of fee-for-service health care, many employer-sponsored plans switched to some form of "managed care." *Id.* at 544. See also Brief of Petitioners at 6. Although it exists in many different permutations, managed care attempts to control costs by integrating the financing and delivery of health care services. See John K. Iglehart, *Health Policy Report: The American Health Care System - Managed Care*, 327 New Eng. J. Med. 742, 742 (1992). As a result, MCOs conflate, to varying degrees, the functions of insurer with that of care provider. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995) (recognizing "that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . . where the benefit contracted for is health care services rather than money to pay for such services . . ."); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1331-32 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992) (discussing the dual roles played by a managed-care entity engaged in utilization review). As a result, MCOs may not only control access to benefits, as did indemnity insurers, they can also affect the actual quality of care patients receive. See 965 F.2d at 1332.

2. ERISA was designed to protect beneficiaries from abuses by those who administer employee welfare plans.

The product of a decade of congressional study, *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 375 (1980), ERISA was designed "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983); *Boggs*, 520 U.S. at 845 (same). ERISA accomplishes this goal by establishing standards of conduct, responsibility, and obligations for fiduciaries of employee benefit plans, and by providing for appropriate remedies. See 29 U.S.C. §§ 1001(b), 1132(a).

In keeping with its "broadly protective purposes," *John Hancock Mut. Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 96 (1993), ERISA provides "a panoply of remedial devices" for participants and beneficiaries of benefit plans." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (quoting *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). ERISA also creates federal fiduciary standards, enacted in response to evidence that benefit plan administrators faced "few and inadequate remedial consequences" for breaching their fiduciary duty to beneficiaries. See Dahlia Schwartz, *Note: Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. Rev. 631, 636 (1999). ERISA requires "the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, . . . [and] establish[es] standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and . . . provid[es] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b); see also *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996).

B. Federal Laws Supporting The Growth Of Managed Care Do Not Establish Any Congressional Intent To Immunize Managed-Care Organizations From Legal Accountability.

Because MCOs assume some or all of the financial risk of providing health care, they have a strong incentive to control costs. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 Am. J. L. & Med. 301, 305 (1996). See also Brief of Petitioners at 3. Managed care promotes more cost-conscious care. See, e.g., Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 Seton Hall. L. Rev. 1009, 1009 n.1 (1996). Financial incentives to physicians for reducing the costs of care are but one of many cost containment strategies used by MCOs. See Iglehart, *supra*, at 742.

Beginning with the federal Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, Congress has sought to encourage the growth of managed care in order to help control health care costs, by reducing inefficiency and waste in the health care system. However, Congress has never immunized health maintenance organizations ("HMOs") or other MCOs from accountability. To the contrary, federal legislation pertaining to managed care has consistently demonstrated Congress' intent to protect the interests of patients, even while promoting cost conscious health care delivery.

1. The federal Health Maintenance Organization Act does not exempt managed-care organizations from ERISA or any other source of legal oversight.

The Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, attempted to spur the growth of private, cost-efficient HMOs and to expand availability of HMO plans to employees. See S. Rep. No. 93-129 (1973), reprinted in 1973 U.S.C.C.A.N. 3033, 3039-40 (noting with approval expert opinion that some form of HMO is

needed to restructure system more efficiently). The Act accomplished these goals by providing loans and loan guarantees to HMOs that met strict federal requirements and by setting criteria for employer-sponsored HMO plans. See 42 U.S.C. §§ 300e-4, 300e-9. Since federal loan availability under the Act ceased in 1986, 42 U.S.C. § 300e-4(d), the law has served primarily an "accreditation function to provide an imprimatur of quality for employers and other payers for HMO services." See Kinney, *supra*, at 314.

Petitioners aver that by supporting the development of HMOs, Congress has unqualifiedly sanctioned managed-care cost-containment measures. Brief of Petitioners at 4, 46. Mere encouragement of HMOs cannot be equated with a judgment that *all* such arrangements are exempt from ERISA or other legal oversight. In fact, federal qualifying criteria for HMOs, including grievance procedures and solvency requirements, indicate Congress' concern that protection of consumers not be sacrificed for cost concerns. See 42 U.S.C. §§ 300e(c)(1) and (5). Moreover, the HMO Act never sanctioned – or even suggested – the eradication of either state laws' or ERISA's essential protections against abuses by fiduciaries of HMO-style employee benefit plans.

2. The managed-care provisions of the Social Security Act demonstrate Congress' intent to protect beneficiaries while encouraging the growth of quality managed care.

Beginning in the 1980s, Congress began promoting enrollment of Medicaid and Medicare beneficiaries in HMOs as a way of reducing federal expenditures. See Kinney, *supra*, at 305-6. Congress thus authorized the Health Care Financing Administration ("HCFA") in 1982 to contract with federally qualified HMOs, see 42 U.S.C. § 300e-9(d), and other approved HMOs and "competitive

medical plans," to provide care to Medicare beneficiaries. 42 U.S.C. § 1395mm(b). With passage of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, Congress expanded the range of managed-care arrangements eligible to be Medicare providers. *See* 42 U.S.C. § 1395w-21(a)(2)(A) (authorizing enrollment in "coordinated care plans," including HMOs, "preferred provider organization plans" and "provider sponsored organizations").

To participate in the Medicare program, managed-care organizations must meet numerous conditions designed to protect beneficiaries. *See* 42 U.S.C. § 1395mm(b)(2); 42 U.S.C. § 1395w-22. These conditions include compliance with open enrollment requirements, disclosure of certain information to beneficiaries, providing "meaningful" procedures for hearing and resolving grievances, and establishing an ongoing quality assurance program. 42 U.S.C. § 1395mm(c) (protections under former risk contract program); 42 U.S.C. §§ 1395w-21(e), 1395w-22(c), (e), (f) and (g) (enhanced protections under Medicare+Choice program).

Congress has also authorized the provision of Medicaid benefits through managed-care arrangements. *See* 42 U.S.C. § 1396b(m). As with the Medicare program, a detailed regulatory scheme exists to protect beneficiaries. In order to qualify as a Medicaid provider, an MCO must ensure access to services, meet solvency standards, not discriminate based on health status, and disclose specified information to beneficiaries. *See id.*

Significantly, Congress expressly restricted the physician incentives allowed in MCOs that contract with the Medicare and Medicaid programs. *See* 42 U.S.C. § 1395mm(i)(8); 42 U.S.C. § 1395w-22(j)(4); and 42 U.S.C. § 1396b(m)(2)(A)(x) (incorporating Medicare rule). Medicare and Medicaid MCOs are prohibited from making payments to physicians, whether direct or indirect, as an

inducement to reduce or limit medically necessary services to a specific enrollee. *See, e.g.*, 42 U.S.C. § 1395w-22(j)(4)(i). Moreover, to ensure against injury to beneficiaries, the statutes require stop-loss insurance protection of physicians and physician groups that are placed at substantial financial risk. *See, e.g.*, 42 U.S.C. § 1395w-22(j)(4)(ii)(I). Finally, the law requires HCFA to monitor the effect of physician incentives on beneficiary access to quality services.² *See, e.g.*, 42 U.S.C. § 1395w-22(j)(4)(ii)(II). The Medicare+Choice statute also prohibits so-called "gag" clauses that prevent physicians from communicating the full range of treatment options to patients. 42 U.S.C. § 1395w-22(j)(3). These provisions, viewed together, reflect Congress' well-founded concern that managed-care financial incentive schemes may have the effect of reducing the services provided to program beneficiaries.

Although the Medicare and Medicaid managed-care laws are not applicable in the instant case, they show that even while promoting managed care, Congress recognized the potential dangers arising from physician incentive schemes. With Medicare and Medicaid, Congress sought to encourage managed care, but not without ensuring adequate protections for the beneficiaries.

² The Medicaid statute also provides for oversight of financial transactions of non-federally qualified HMOs that potentially pose a conflict of interest. *See* 42 U.S.C. § 1395b(m)(4)(A) (requiring disclosure of transactions between Medicaid MCO and party in interest).

II. WHERE CLAIMS PERTAINING TO THE CREATION OF A FINANCIAL INCENTIVE SCHEME HAVE BEEN HELD PREEMPTED BY ERISA, THEY MUST BE FOUND TO CONCERN THE ACTIONS OF A FIDUCIARY UNDER ERISA.

A. The Concept Of A Fiduciary Under ERISA Must Be Understood In Light Of The Statute's Goals And Its Relationship To State Law.

The fiduciary has been aptly termed the "linchpin" in ERISA's scheme of flexible regulation. John H. Lanbein & Bruce A. Wolk, *Pension and Employee Benefit Law* 626-627 (2d ed. 1995). The essential role played by the fiduciary must be understood in light of ERISA's scheme of cooperative federalism. See 29 U.S.C. § 1144(a). As this Court has recently noted, ERISA preemption of state laws regulating matters traditionally left to the state, such as health care, is not to be lightly presumed. See *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995). Moreover, to the extent that preemption is appropriate to prevent potentially disuniform regulation of employee benefit plans,³ it should not be read to shelter entities that administer such plans from any legal oversight, "but rather as a means to promote the principal object of ERISA as a whole - 'to protect plan participants and beneficiaries.'" *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 58 (D. Mass. 1997) (emphasis added). Federal displacement of state law does not erase any and all accountability. Thus, when a state law action

³ Even when a state law or action "relates to" an employee benefit plan, it will not be preempted if it falls within the scope of ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A), and does not implicate the "deemer clause," 29 U.S.C. § 1144(b)(2)(B) (1999). See *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, ___, 119 S. Ct. 1380, 1386 (1999). The instant case does not implicate either clause, as the respondent did not bring her initial action under a state law regulating insurance. Petition for Certiorari at 66a.

is preempted because the matter "relates to" an ERISA plan, the presumption must be that the matter falls within ERISA's fiduciary-based system of regulation.⁴ For if there is no ERISA jurisdiction over the matter, it is difficult to see how the state action "relates to" an ERISA plan. But when a state law is found to "relate to" plan administration on the grounds that it concerns actions of the defendants as fiduciaries, the same actions cannot then be held outside ERISA's fiduciary duties as merely "indirect" provision of services. See Brief of Petitioners at 18. Either the federal or the state system must have jurisdiction over the matter. There is no extra-territorial immunity for plan administrators.

B. Petitioners' Untenable And Unprecedented Goal - Immunity From Both State And Federal Oversight For Their Alleged Breaches - Should Be Rejected By This Court As An Improper Effort To Manipulate ERISA Preemption.

Petitioners seek to benefit from ERISA's preemptive shield without coming under ERISA's scrutiny. In resisting the motion to remand the case to state court, petitioners admitted to being fiduciaries within the meaning of ERISA, implicitly conceding that they were subject to ERISA's fiduciary duties. *Herdrich v. Pegram*, 154 F.3d 362, 369 n.5 (7th Cir. 1998), rehearing en banc denied, 170 F.3d 683 (1999). Now, after successfully arguing for preemption and a federal forum,⁵ petitioners claim before this

⁴ This is not to say that an individual plaintiff will prevail under ERISA whenever a state law claim is preempted. ERISA provides its own standards of behavior, which will often differ from those applicable at state law. In addition, even when ERISA applies to a claim, relief may be unavailable. See, e.g., *Mertens v. Hewitt Associates*, 508 U.S. 248, 260-61 (1993).

⁵ In its opinion in favor of the respondent, the Seventh Circuit noted that the parties "took dramatically different

Court that they are not fiduciaries. Brief of Petitioners at 22-42. In addition, they attempt to turn their exercise of removal jurisdiction on its head, arguing that the decision below undermines principles of federalism by paving the way for excessive preemption. Brief of Petitioners at 38. In making this argument, petitioners forget that it was they who successfully sought preemption in the first place, and that they already prevailed upon that issue.

Petitioners' extraordinary attempt to play state and federal jurisdiction against each other and convert preemption into total immunity from legal oversight is without precedent. Even those who have argued that ERISA preemption is too broad have done so in the belief that ERISA's remedies are often inadequate. *See, e.g., Corcoran*, 965 F.2d at 1331; *Andrews-Clarke*, 984 F. Supp. at 59. *See also* Jayne Elizabeth Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 Wash. U. L.Q. 671 (1994). But no authority has suggested that ERISA is entirely inapplicable to an action that has previously been preempted. Indeed, petitioners do not cite a single case in which a federal court has excused a defendant altogether from accountability

positions from what they now argue on appeal concerning the issue of whether the defendants were plan fiduciaries . . . Herdrich originally maintained that the defendants were not plan fiduciaries, while the defendants insisted that they were." *Herdrich v. Pegram*, 154 F.3d 362, 369 n.5 (7th Cir. 1998), *rehearing en banc denied*, 170 F.3d 683 (1999). This Court has held that "where a party assumes a certain position in a legal proceeding, and succeeds in maintaining that position, he may not thereafter, simply because his interests have changed, assume a contrary position, especially if it be to prejudice the party who has acquiesced in the position formerly taken by him." *Davis v. Wakelee*, 156 U.S. 680, 689 (1895) (citations omitted); *cf. Utermehle v. Norment*, 197 U.S. 40, 57-58 (1905) (holding that one who receives a beneficial interest pursuant to a will is estopped from later challenging the validity of the will).

after that defendant prevailed in preempting a state claim on grounds that the state claim implicated the defendant's status as an ERISA plan fiduciary. Heretofore, the federal courts have either found preemption and proceeded to determine whether a fiduciary breach has occurred, *e.g., Smith v. Provident Bank*, 170 F.3d 609, 612 (6th Cir. 1999); *Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 172 (3d Cir. 1997); *Corcoran*, 965 F.2d at 1331, or remanded the case back to state court. *E.g., Dukes v. U.S. Healthcare, Inc.*, 57 F.3d at 356-57 (finding complete preemption inappropriate in an analysis that suggests that state law should not be preempted).

Nowhere is there a greater need to recognize the interrelationship between preemption and federal jurisdiction over fiduciaries than with HMOs, which blur traditional divisions among health care providers, health insurers and plan administrators. Brief of Petitioner at 3-4; Solicitor General's Brief at 11-13, 24-27. *See also* Rand E. Rosenblatt et al., *supra*, at 544. This difficulty in ascertaining the actual role, or roles, played by an HMO in a given situation has complicated the ERISA analysis. *Dukes*, 57 F.3d at 361.

In the last few years, however, courts have held that when managed-care entities are performing a clinical role, as providers of health care, they are not ERISA fiduciaries. *Id.* Hence, claims challenging the *quality* of care are appropriately left to state law. *Id.* Conversely, claims pertaining to the determination of benefits by managed-care entities are generally preempted but subject to review under ERISA. *See, e.g., Corcoran*, 965 F.2d at 1331.

Count III of Ms. Herdrich's amended complaint does not challenge clinical decisions made by the petitioners. Indeed, the clinician who treated Ms. Herdrich, Dr. Pegram, was not a party to Count III. *See* Petition for Certiorari at 84a. Petitioner HAMP is not a clinician, but rather a domestic stock insurance company entrusted by

the State Farm ERISA plan to manage the HMO option. Brief of Petitioners at 6-7. In other words, although the plan HAMP managed for State Farm's employee benefit plan was an HMO option (with care provided by Carle Clinic), *id.*, HAMP itself acted as a plan administrator, *not* a health care provider.

The fact that, like many HMOs, petitioners commingled the roles of insurer, administrator and provider (in that HAMP's directors were also the owners and physicians of Carle Clinic, *see id.*) does not permit them to escape accountability for their activities as overseers of the employee benefit plan. To the extent that petitioners, especially HAMP, controlled access to State Farm plan benefits and were therefore able to preempt the respondent's state law claims, they should be treated as fiduciaries under ERISA. The complexity of managed care does not free its players from legal oversight. There is no void lying between state and federal law.

C. A Party's Status As A Fiduciary Under ERISA Turns On Its Function Rather Than Its Form.

Assuming that state law has properly been preempted, the determination of whether the petitioners are fiduciaries must be made consistent with the goals and text of ERISA itself. As this Court has noted, ERISA:

says that a "person is a fiduciary with respect to a plan," and therefore subject to ERISA fiduciary duties, "to the extent" that he or she "exercises any discretionary authority or discretionary control respecting management" of the plan, or "has any discretionary authority or discretionary responsibility in the administration" of the plan.

Varity Corp., 516 U.S. at 498, *citing* ERISA § 3(21)(A). Consistent with ERISA's policies and objectives, the statutory definition of a "fiduciary" is construed liberally. *See, e.g., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav.*

Bank, 510 U.S. 86, 96 (1993); *Smith v. Hartford Ins. Group*, 6 F.3d 131, 141 n.13 (3d Cir. 1993), *cert. denied*, 522 U.S. 932 (1997). Fiduciary status under ERISA is not an "all-or-nothing concept," *see* Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DePaul Bus. L. J. 189, 191 (1997), *citing* *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1465 (4th Cir. 1996), but rather, enables a party who wears "two hats," *see* *Amato v. Western Union Int'l, Inc.*, 773 F.2d 1402, 1416-17 (2d Cir. 1985), *cert. dismissed*, 474 U.S. 1113 (1986), to be considered a fiduciary "to the extent" that the hat worn permits discretion or control over the ERISA plan. *See id.*; *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 233-34 (3d Cir. 1994). *See also* *Varity Corp. v. Howe*, 516 U.S. 489, 498 (1996). Accordingly, ERISA expands the universe of persons subject to fiduciary duties by defining fiduciary "not in terms of formal trusteeship, but in functional terms of control and authority over the plan." *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 262 (1993), *citing* 29 U.S.C. § 1002(21)(A). This liberal and functional approach to fiduciary status is especially appropriate where preemption has occurred.

Petitioners attempt to evade this approach by arguing that the sole "benefit" available to State Farm plan beneficiaries like respondent is "membership in the Carle Care HMO." Brief of Petitioners at 25. This argument ignores this Court's prior analysis which rejects such an unduly narrow version of what constitutes the "benefit" available to a plan participant. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43-44 (1987). When coupled with petitioners' position on preemption, this view would undermine the broad protections and intentions of ERISA. Tellingly, the petitioners point to no authority for their position (aside from Judge Easterbrook's dissent, *see Herdrich v. Pegram*, 170 F.3d 683 (7th Cir. 1999) (Easterbrook, J., dissenting)), because there is nothing in ERISA or its legislative history to suggest such a radical diminution of accountability. To the contrary, in applying

ERISA's fiduciary definition in the managed-care context, the federal courts have found that if, as respondent alleges, Petition for Certiorari at 85a, an HMO exercises discretion and control over the administration or management of the plan, the HMO is acting as a fiduciary for purposes of ERISA.⁶ See, e.g., *Shea v. Esenstein*, 107 F.3d 625, 628-29 (8th Cir.), cert. denied, 522 U.S. 914 (1997); *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997); *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757, 761 (D.N.H. 1997). See also Cantor, *supra*, at 191-92 ("Each of the parties involved in operating a modern health plan can be a fiduciary with respect to those activities over which it has discretion. Those parties include the plan sponsor, insurer, third-party administrator, and various types of managed care entities, among others.").

Contrary to petitioners' suggestion, the Court of Appeals' decision does not demand that ERISA fiduciary status be found whenever "any act or decision by a health-care provider [. . .] indirectly affect[s] benefits provided under an ERISA plan." Brief of Petitioners at 31 (emphasis added). Rather, as the Solicitor General aptly

⁶ The duty to disclose material information is at the core of a fiduciary's responsibility under the common law of trusts. Trustees must neither mislead nor deceive plan beneficiaries. *Varity Corp.*, 516 U.S. at 506. The first two courts to consider whether ERISA requires MCOs to disclose the existence of physician incentive schemes to enrollees found the MCOs in question to be ERISA fiduciaries. See *Shea v. Esenstein*, 107 F.3d 625 (8th Cir.), cert. denied, 522 U.S. 914 (1997); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (S.D.N.Y. 1997). A holding that petitioners are neither subject to state law nor acting as ERISA fiduciaries in devising a financial incentive scheme, in which savings resulting from the withholding of care went into the physician-owners' pockets, would implicitly mean that *Shea* and *Weiss* were wrongly decided.

asserts in his *amicus* brief to this Court, in the context of managed care:

[I]nsofar as an HMO exercises "discretionary authority or discretionary responsibility in the administration of the plan, it takes on fiduciary status under ERISA. 29 U.S.C. § 1002(21)(A). Activities that constitute administration of the plan include determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records to comply with applicable reporting requirements. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). In the context of the HMO, the relevant administrative functions frequently performed by an HMO consist of determining eligibility under the ERISA plan, determining whether a particular treatment is covered by the plan, sending required notices and filing reports, and keeping necessary records. An HMO is an ERISA fiduciary only when and insofar as it exercises discretionary control over those activities.

Solicitor General's Brief at 18-19 (internal quotations omitted).

In this case, respondent has alleged that petitioners exercise significant discretion over the activities detailed above. As the Seventh Circuit found, the respondent's complaint alleged, *inter alia*, that the petitioners were "in control of each and every aspect of the HMO's governance . . . [and] had the exclusive right to decide all disputed and non-routine claims." *Herdrich*, 154 F.3d at 370. The Court of Appeals concluded correctly that the petitioners' degree of control and discretion – particularly their control and discretion over the granting or denial of benefits – was sufficient to satisfy ERISA's fiduciary requirements. *Id.* Other courts have likewise found the controllers of managed-care plans to be fiduciaries. See,

e.g., *Bailey v. Blue Cross & Blue Shield of Virginia*, 67 F.3d 53, 56 (4th Cir. 1995), cert. denied, 516 U.S. 1159 (1996); *Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995); *Florence Nightingale Nursing Serv. v. Blue Cross & Blue Shield of Alabama*, 41 F.3d 1476, 1478-79 (11th Cir.), cert. denied, 514 U.S. 1128 (1995); *Pacificare, Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994); *Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut.*, 982 F.2d 1031, 1035 (6th Cir.), cert. denied, 510 U.S. 819 (1993); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416, 419 (7th Cir.), cert. denied, 488 U.S. 856 (1988).

The court's analysis in *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757 (D.N.H. 1997), is pertinent. In *Drolet*, the defendants, a health care corporation and its wholly-owned HMO subsidiary, argued that they were not ERISA fiduciaries, and therefore, could not be held liable for misrepresentations or omissions regarding the financial incentive scheme employed to reward physicians for reducing health care expenditures. See *id.* at 758, 760. In denying defendants' motion to dismiss, the court relied on ERISA's use of the term "control" in the statutory definition of fiduciary. The court stated:

The term "control" in the [statutory definition of fiduciary] has been interpreted as "the power to exercise a controlling influence over the management of policies of a person other than an individual." 29 C.F.R. § 2510.3-21(e)(2) (1996). [The plaintiff] satisfactorily alleges in her complaint that [the HMO] has the discretionary authority and control over the plan to qualify it as a fiduciary. Moreover, [the HMO] conceded at the hearing on the motion to dismiss that it exercises final control over benefits appeals. As such, it plainly qualifies as a fiduciary under ERISA. See *Varity Corp.*, 116 S.Ct. at 1077; *Libbey-Owens-Ford Co. v. Blue Cross and Blue Shield Mut.*, 982 F.2d 1031, 1035 (6th Cir. 1993); *American Fed'n of Unions v. Equitable Life Assurance Soc'y*,

841 F.2d 658, 663 (5th Cir. 1988). [The plaintiff] also adequately alleges that [the corporate owner] controls the policies and practices of [the HMO] to such an extent that it also exercises control over the management and policies of the plan. See *Johnson v. Flowers Indus.*, 814 F.2d 978, 981 (4th Cir. 1987).

Drolet, 968 F. Supp. at 761 (other citations and parentheticals omitted). Although obviously not binding on this Court, *Drolet* provides a useful paradigm for analyzing the application of ERISA's fiduciary concepts to managed care.

Petitioners suggest that even if they are fiduciaries in some respect, the allegations of Count III do not implicate actions they undertook in that capacity. First, petitioners argue that the financial incentive scheme at issue is a matter of plan design and therefore is not subject to ERISA's fiduciary standards. Brief of Petitioners at 26-30. Although petitioners correctly state that decisions of the employer-settlor in determining the nature and extent of benefits do not constitute fiduciary action, see 29 U.S.C. § 1002(1), there is nothing in the record to suggest that State Farm knew or approved of the specific incentive plan that serves as the basis for Count III. The fact that State Farm's ERISA plan offered a managed-care product that utilized cost-containment measures does not mean that it chose – let alone required – the particular financial incentive scheme at issue here.

Many courts have held that through the discretionary administration of employee health plans, including the development of physician incentive schemes, managed-care organizations assume ERISA fiduciary status. See, e.g., *Shea v. Esensten*, 107 F.3d 625, 627 (8th Cir.), cert. denied, 522 U.S. 914 (1997); *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1386 (11th Cir. 1990); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997); *Morales v. Health Plus, Inc.*, 954 F. Supp. 464, 468 (D.P.R. 1997). Based on similar reasoning, the court in *Corcoran v. United*

HealthCare, Inc., 965 F.2d at 1331, after preempting state law claims, held that a "utilization review" by a utilization review organization⁷ constituted administration of an ERISA benefits plan and was subject to review under ERISA. As with utilization review, a physician incentive plan designed to reduce care implicates, albeit indirectly, the availability of benefits under a managed-care ERISA plan. The simple fact that petitioners created a scheme designed to influence access to benefits rather than engage in a case-by-case determination of coverage does not alter the discretionary, administrative nature of the activity and hence, their fiduciary status.

III. ALLEGATIONS THAT A FIDUCIARY ESTABLISHED AN INCENTIVE SCHEME TO BENEFIT THE FIDUCIARY'S PRINCIPALS BY DISCOURAGING PROVISION OF CARE STATE A COGNIZABLE CLAIM FOR BREACH OF FIDUCIARY DUTY UNDER ERISA.

A. An ERISA Fiduciary's Sole Obligation, With Or Without Dual Loyalties, Is To Act In The Interests Of The Beneficiaries.

When a state law action against a MCO has been preempted and the MCO is found to be a fiduciary, the MCO becomes subject to ERISA's fiduciary duties. In contrast to pension plans, about which ERISA contains myriad specific regulations, *see* 29 U.S.C. §§ 1054-56, 1081,

⁷ Utilization review organizations hire physicians and nurses to review each insured patient's records to determine if prescribed treatments are medically necessary. *See* Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. Marshall L. Rev. 207, 216 (1997). If the reviewer determines that the treatment is not medically necessary, the beneficiary does not receive the treatment. *See id.*

1221-1222, the statute has few detailed requirements pertaining to welfare plans. The beneficiaries of welfare plans, however, are not left without legal protection, for ERISA explicitly asserts that its sections pertaining to "fiduciary responsibilit[ies]" apply to "any employee benefit plan." 29 U.S.C. § 1001(a)(1). Nothing in the statute exempts the fiduciaries of health plans in general, or managed-care health plans in particular, from those responsibilities.

First and foremost among the fiduciary responsibilities is the duty of loyalty. ERISA states that the plan's fiduciary "shall discharge his duties with respect to a plan solely in the interests of the participants and beneficiaries and (a) for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1101(a). The statute further provides that plan assets may not be used except in specified circumstances (none of which are applicable here) for the "benefit of a party in interest." 29 U.S.C. § 1106(a)(1)(d).

ERISA's duty of loyalty derives from the common law of trusts. *See* S. Rep. No. 93-127 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4864 ("The fiduciary responsibility section, in essence, codifies and makes applicable to these fiduciaries certain principles developed in the evolution of the law of trusts"). *See also* *Varity Corp. v. Howe*, 516 U.S. at 506 (discussing the relationship between ERISA's duty of loyalty and the common law of trusts.) As a result, courts are to look to common law principles in deriving the meaning and content of ERISA's duty of loyalty. *See id.*; *Firestone Tire and Rubber*, 489 U.S. at 110.

Under common law, the duty of loyalty was the "most fundamental duty owed by a trustee to the beneficiaries. . . ." IIA *Scott on Trusts* § 170, at 311 (4th ed. 1987). As Justice Benjamin Cardozo noted almost three-quarters of a century ago: "A trustee is held to something

stricter than the morals of the marketplace. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior." *Meinhard v. Salmon*, 249 N.Y. 458, 464, 164 N.E. 545, 546 (1928). In order to enforce this very strict requirement, the law of trusts forbids absolutely many forms of self-dealing by fiduciaries, even when such self-dealing may not result in harm to the beneficiary. See *IIA Scott on Trusts, supra* at § 170, at 311-312.

The common law of trusts, however, is merely a jumping-off point for interpreting ERISA's duty of loyalty. As this Court has noted, when construing ERISA, courts must look not only to the common law but also to "Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.*, 516 U.S. at 497.

In recognition of these multiple goals, ERISA stops short of declaring certain conflicts of interests by fiduciaries as per se breaches of fiduciary duty. Laurence B. Wohl, *Fiduciary Duties Under ERISA: A Tale of Multiple Loyalties*, 20 Dayton L. Rev. 43, 55 (1994). Most notably, ERISA permits employers and their agents to serve as fiduciaries, even when this presents certain conflicts of interest. This limited tolerance of conflicts of interest by employers and their agents is consistent with the statute's goal of encouraging employers to establish employee welfare plans. There is no need for such an accommodation of dual loyalties where, as here, the fiduciary has played no part in establishing the welfare plan and the alleged conflict arises from the fact that it is the directors of HAMP, as physicians, who may benefit personally from denying beneficiaries access to promised benefits. Petition for Certiorari at 86a. This conflict has no relation

at all to ERISA's goals of encouraging employers to establish welfare plans.

Although ERISA permits fiduciaries in some circumstances to have dual loyalties, it does not permit them, when acting in their fiduciary role, to make decisions that advance their interests to the detriment of the beneficiaries. To the contrary, fiduciary actions must be taken with an "eye single" to the interest of the beneficiaries. *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982). See also *Leigh v. Engle*, 858 F.2d 361, 364 (7th Cir. 1988); *Pitman v. Blue Cross & Blue Shield of Oklahoma*, 24 F.3d 118, 123 (10th Cir. 1994). Any other outcome would eviscerate the very notion of a fiduciary and would make meaningless ERISA's edict that fiduciaries act in the interest of the beneficiaries. 29 U.S.C. § 1104(a)(1). This Court has never condoned such a departure from basic fiduciary principles.

Applying ERISA's fiduciary obligations to managed care, when state law is preempted, will not, as petitioners imply, Brief of Petitioners at 46, threaten the existence of managed-care plans. The fiduciary's obligation is not to please a particular beneficiary but to afford the beneficiary the benefits promised by the plan, typically medically necessary care, while preserving the interests of the plan as a whole. Thus, where a health benefit plan expressly limits benefits (as does the plan at issue), Joint Appendix at 83-88 (limiting coverage of prescription drugs, ineligible charges and pre-existing conditions), an ERISA fiduciary does not violate its obligations by denying those benefits. E.g., *Fuja v. Benefit Trust Life Insurance Co.*, 18 F.3d 1405, 1411 (7th Cir. 1994). However, where as here, a fiduciary devises a system that limits the beneficiaries' ability to obtain benefits promised in order to promote the interests of the fiduciary and its principals, a breach of trust has occurred.

B. When Acting In The Fiduciary Role, Plan Administrators Are Not Free To Ignore Their Conflict Of Interest But Must Seek To Bring Their Conflicting Interests To A Resolution Consistent With ERISA's Goals.

The petitioners misapply the teaching of *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 119 S. Ct. 755 (1999). In *Hughes*, an employer, acting in his nonfiduciary capacity, amended a pension plan. The Court held that the employer's concurrent but separate fiduciary status as administrator of the pension plan's assets was not implicated, despite the fact that the employer was acting in its financial self-interest to the detriment of its employees. 119 S. Ct. at 760-63. Essentially, the Court held that as long as the decision is taken while acting outside the fiduciary role, fiduciary principles do not apply.⁸ *Id.*

The *Hughes* scenario does not exist in this case. Ms. Herdrich is challenging the incentive scheme created by the petitioners, primarily HAMP, in contracting with Carle Clinic for medical services. Petition for Certiorari at 84a-87a. To the extent that these actions have been found to be outside the purview of state law, and within the realm of ERISA, they are solely actions undertaken as a fiduciary, not as a settlor. Within ERISA's framework, the conflict is not between two roles, one fiduciary and one non-fiduciary, as in *Hughes*. The conflict that exists here arises in the exercise of the fiduciary role itself.

The distinction between a case where a fiduciary is acting in dual roles and one in which the conflict arises solely in connection with the exercise of a fiduciary obligation is crucial. *Hughes* stands for the proposition that an

⁸ The observations regarding *Hughes* are equally applicable to *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996). The *Lockheed* Court held that plan sponsors who alter the terms of a plan do not fall into the category of fiduciaries because their actions are analogous to those of the settlors of a trust. *Id.* at 891.

employer may disregard the interests of employees when amending its pension plan. But as this Court has emphasized repeatedly, *see, e.g., Varity Corp.*, 516 U.S. at 506, when a fiduciary is operating *within* its fiduciary role, the duty of loyalty to plan beneficiaries is paramount.

ERISA fiduciaries, of course, often face a conflict between loyalty to pension plan beneficiaries and cost-containment measures which benefit the plan as a whole. As the Court stated in *Mertens*, "[t]here is . . . a tension between the primary ERISA goal of benefiting employees and the subsidiary goal of containing pension costs. We will not attempt to adjust the balance between those competing goals that the text adopted by Congress has struck." 508 U.S. at 262-63 (internal quotation marks, brackets and citations omitted).

Likewise, a tension exists whenever a health plan administrator must decide whether to authorize medical care, as such a decision affects the plan's financial health. In many such cases, federal courts have attempted to find a measured way to heighten the scrutiny of the plan administrator's decision, in recognition of the inherent conflicts. *See, e.g., Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826-27 (10th Cir. 1996); *Doe v. Group Hospitalization Medical Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Brown v. Blue Cross and Blue Shield of Alabama*, 898 F.2d 1556, 1568 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991). *See generally* Michael A. de Fraitas, *Annotation: Judicial Review of Denial of Health Care Benefits Under Employee Benefit Plan Governed by Employee Retirement Income Security Act (ERISA)* (29 U.S.C.A. § 1132(a)(1)(B)) – *Post Firestone Cases*, 128 A.L.R. Fed. 1 (1999). These courts, however, have never suggested that fiduciary duty principles are inapplicable due to such conflicts of interest.

Petitioner HAMP, like the plan administrator in the typical benefits administration case, was faced with the inherent conflict between saving the ERISA plan money

and serving the interests of the beneficiaries. But, according to the respondent's allegations in Count III, Petition for Certiorari at 84a-87a, which must be taken as true when reviewing a decision pertaining to a motion to dismiss, *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957), HAMP and its alter-ego Carle Clinic opted to serve a third interest – their own. Thus, HAMP devised a plan that would benefit its principals to the detriment of the beneficiaries. Such self-dealing in a fiduciary capacity is critically different than the balancing of interests inherent in the ordinary administration of an ERISA plan. Where, as here, a plaintiff alleges that an incentive system is designed to deprive beneficiaries of the medical benefits promised by the plan, a cause of action for breach of fiduciary duty exists under ERISA.

C. Courts Are Well-Equipped To Review Allegations Of Breach Of Trust By Administrators Of Managed-Care Plans.

Federal courts have ample guides to help address the inherent conflict that exists in managed-care plans. Far from spelling the end of managed care, review of managed-care incentive schemes under ERISA is well within the competence of the courts. This is particularly true where the conflicts by HMO administrators mirror those addressed by ERISA – the protection of employee benefits and the controlling of costs.

Although the primary goal of ERISA is protection of employees, it is not the exclusive goal. *Mertens v. Hewitt Associates*, 508 U.S. 248, 262-63 (1993) (Scalia, J.) (quoting *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 515 (1981)). ERISA's subsidiary goal is containment of costs, and ERISA is founded on the premise that these two goals can be harmoniously resolved.

MCOs use a variety of approaches to achieve this balance. Most approaches are consistent with ERISA's

goals.⁹ For example, capitation systems can advantage plan beneficiaries if the availability of a steady stream of payments permits providers to institute preventive care programs for enrollees. See, e.g., Stephen R. Lathan, *Regulation of Managed Care Incentive Payments to Physicians*, 22 Am. J. Law & Med. 399, 401 (1996). As long as the incentives are chosen by the plan administrator to serve the interests of plan beneficiaries first, and itself second, the duty of loyalty is preserved. However, an incentive system that imprudently promotes under-utilization of medical care and benefits the administrator's own principals is a different matter.¹⁰ Cf. *Schaefer v. Arkansas Medical Society*, 853 F.2d 1487, 1492 (8th Cir. 1988) (holding that a fiduciary with dual loyalties must follow the prudent person standard).

Although respondents were prevented from taking any meaningful discovery as to the specifics of the incentive scheme, the record reveals that the plan at issue here is not representative of the typical HMO. HAMP devised a system in which its physician-owners directly benefited

⁹ For example, managed care was originally known for its focus upon prevention, which may lower costs but also improve the patients' quality of health. See, e.g., Jack K. Kilcullen, *Groping the Reins: ERISA, HMO Malpractice and Enterprise Liability*, 22 Am. J. Law & Med. 7, 21 (1998) ("Paul Elwood coined the term health maintenance in 1970 to stress the preventative nature of this form of pre-paid care."); Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 Ga. L. Rev. 419, 427-29 (1997).

¹⁰ The American Medical Association's Council on Ethical and Judicial Affairs has recognized this danger, warning that under some circumstances, managed care may lead physicians to "cut corners in their patient care, by temporizing too long, eschewing extra diagnostic tests, or refraining from an expensive referral." Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330, 333 (1995). See also Marc A. Rodwin, *Medicine, Money and Morals: Physicians' Conflict of Interest* 145 (1993).

at the expense of the beneficiaries and the plan. Brief of Petitioners at 27, 33. Petitioners assert that physician-owners are no more likely than corporations or other HMO owners to contain costs at the expense of patient welfare, *id.* at 47, yet they ignore the fact that in the typical case, the same physicians do not act as both providers and administrators of the plan. Here, in contrast, petitioners faced multiple conflicts of interest beyond those posed in the more common scenario. If, acting under such conflicts, they devised a scheme that was designed to profit their principals to the detriment of the beneficiaries, they violated their duty of loyalty under ERISA.

D. Preservation Of A Cause Of Action For Breach Of Fiduciary Duty In A Managed-Care Setting Will Neither Threaten The Viability Of Managed Care Nor Open The Floodgates To Litigation.

Petitioners assert that permitting a cause of action for breach of fiduciary obligation by administrators of a managed-care plan will force courts to engage in the difficult and inappropriate task of distinguishing good managed-care policies from bad ones. *See* Petition for Certiorari at 11. In actuality, it would be the negation of this congressionally enacted cause of action that would constitute an inappropriate act of judicial policymaking.

Enforcement of ERISA's fiduciary obligations in the managed-care context will not require courts to create a new cause of action or undertake inappropriate policymaking. The issue before the Court in such cases is not the wisdom of managed care or even the best way to run a managed-care plan.¹¹ The matter before the Court is

¹¹ Indeed, the decision whether an employee benefit plan shall be a managed-care plan is primarily the decision of the

simply the factual question of whether a particular fiduciary acted in its own interest in carrying out the plan. Resolving such cases requires no unusual policy judgments by the courts. It merely requires the courts to look carefully at the facts of a particular case and determine, as courts routinely do in other cases alleging breach of fiduciary obligation under ERISA, *e.g.*, *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982); *Reich v. Compton*, 57 F.3d 270, 290-91 (3d Cir. 1995), whether the fiduciary has acted to benefit itself, rather than the beneficiaries as a whole.

Because conflicts of interest are not impermissible *per se* and because actions undertaken by a "prudent" fiduciary are generally not considered evidence of impermissibly disloyal actions, *see Bierwirth*, 680 F.2d at 271, such determinations are likely to be rare. Any further fear of a flood of litigation should diminish when it is recalled that ERISA does not provide individual plaintiffs with extra-contractual damages. *See, e.g.*, *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144 (1985). An individual beneficiary thus has no incentive to bring a frivolous claim. But in enacting 29 U.S.C. § 1132(a)(2), Congress clearly intended to enable beneficiaries to obtain equitable relief when a plan fiduciary abuses its trust and attempts to enrich itself to the beneficiaries' detriment. Congress never excluded the beneficiaries of health plans from that right, nor did it license breach of trust by health plan administrators. There is no reason or authority for this Court to do so.

employer in establishing the plan. There can be no breach of fiduciary duty as long as the fiduciary correctly carries out the plan's instructions. Thus, the suggestion by petitioners that recognition of this cause of action dooms managed care is completely off the mark. *See, e.g.*, Petition for Certiorari at 24-25. To the extent that particular forms of managed care are required by an ERISA plan, they will be untouched by any action under 29 U.S.C. § 1132(a)(2).

CONCLUSION

For the reasons stated herein, *amici* respectfully request that this Court affirm the decision below.

Respectfully submitted,

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APPENDIX A

Health Care For All is a non-profit statewide membership organization based in Boston. HCFA seeks fundamental health care reform for Massachusetts' consumers through policy efforts, advocacy, community organization and public education.

The American Psychiatric Association (APA), with more than 40,000 members, is the Nation's largest organization of physicians specializing in psychiatry. It has participated in numerous cases in this Court, including *Olmstead v. Zimring*, 119 S. Ct. 2176 (1999), *Kansas v. Hendricks*, 521 U.S. 346 (1997), *Jaffee v. Redmond*, 518 U.S. 1 (1996), and *Riggins v. Nevada*, 504 U.S. 127 (1992). The members of the APA have a strong interest in ensuring that decisions about medical care be made in the best interests of patients, without being compromised by the financial pressures often present in managed-care settings or by the dual roles, creating potential conflicts of interest, of the sort alleged in this case.

The Center for Health Care Rights is a California-based non-profit health care consumer advocacy organization dedicated to protecting the rights of health care consumers and working to assure consumer access to quality health care through education, counseling, advocacy and research.

Community Catalyst is a Boston-based national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality affordable health care for all.

App. 2

Connecticut Citizen Action Group is a non-profit consumer advocacy organization based in West Hartford that directs the Health Care For All Coalition, a group of 36 organizations committed to advancing universal access to public health care and reversing the commodification of the health care system.

Consumers for Affordable Health Care Foundation is a non-profit public charity based in Augusta, Maine, whose mission is to assist Maine people in obtaining access to affordable, quality health care. CAHCF accomplishes its mission through advocacy, community organizing, public outreach and education, litigation, and participation in rulemaking proceedings.

Greater Upstate Law Project, Inc. is a non-profit law firm located in Rochester, New York, which represents low-income people throughout upstate New York, and provides legal support services to New York state legal services offices and community groups on civil legal matters that affect their lives and their clients' living, including Medicaid, Medicare and access to health care.

Health Administration Responsibility Project, Inc. is a non-profit California corporation devoted to advocacy, education, and representation of members of Managed Care Organizations.

National Health Law Program is a national non-profit law office that seeks to preserve and improve health care services and health insurance coverage for America's working and unemployed poor through education, advocacy, and policy analysis.

App. 3

New Hampshire Citizens Alliance is a non-profit membership organization based in Concord that seeks fundamental health care reform through policy efforts, advocacy, community organizing and public education.

Northwest Health Law Advocates is a non-profit organization based in Seattle, Washington, that promotes increased access to health care and basic health care rights and protections for all individuals, through legal and policy advocacy, education and support to community organizations in the Pacific Northwest.

Public Interest Law Center is a non-profit organization established to provide legal advocacy that addresses systemic social and political problems facing residents of New Jersey. One of its focus areas is the growth of managed-care companies and their impact on the delivery of health care from the perspective of patients and providers.

Texas Citizen Fund is a non-profit organization based in Austin, which provides analysis of consumer issues, develops innovative policy and alternatives to existing policies that adversely affect the state's working poor and moderate income families, and builds networks of consumers across the state.

Texas Heart is a non-profit organization dedicated to providing Texans health education, assistance, resources, and training, with a current focus on providing client advocacy on health related matters.

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No. 98-1949

Supreme Court, U.S.

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In the
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRIEF OF *EHLMANN* PLAINTIFFS
AS *AMICUS CURIAE*
SUGGESTING AFFIRMANCE

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TABLE OF CONTENTS

	<i>Page</i>
Table of Cited Authorities	iii
Interest of the <i>Amicus Curiae</i>	1
Summary of Argument	4
Argument	9
I. ERISA's legislative history shows that common law trust principles provide the key element of an ERISA breach of fiduciary duty claim arising out of fiduciary conflicts of interest: non-disclosure of material facts.	9
II. Petitioners' dual roles as ERISA fiduciaries and health care providers (or "arrangers of care") give rise to conflicts of interest that must be disclosed to avoid a breach of ERISA fiduciary duty claim.	15
A. <i>Conflicts of interest arise with Petitioner HMO acting in the dual roles of health care provider and ERISA plan fiduciary.</i>	15
B. <i>Case law consistently upholds ERISA section 404's broad fiduciary duty of loyalty, including the fiduciary duty to disclose material information for the protection of ERISA plan participants and beneficiaries.</i>	18

Contents

	Page
C. <i>The Seventh Circuit's finding that the financial incentive arrangements implemented by Petitioner HMO give rise to an ERISA breach of fiduciary duty claim should be affirmed with the clarification that the breach occurs in the absence of full disclosure by an ERISA fiduciary.</i>	24
III. Petitioner HMO's argument that it implements the financial incentive arrangements in its health care provider role misses the point: conflicts of interest arise out of self-dealing financial incentives that, in its ERISA fiduciary role, Petitioner HMO must disclose or there is a breach of ERISA's broad fiduciary duties.	27
Conclusion	30

TABLE OF CITED AUTHORITIES

	Page
Cases:	
<i>Anweiler v. American Elec. Power Serv. Corp.</i> , 3 F.3d 986 (7th Cir. 1992)	22, 25
<i>Bailey v. Blue Cross/Blue Shield of Va.</i> , 866 F. Supp. 277 (E.D. Va. 1994), <i>aff'd</i> , 67 F.3d 53 (4th Cir. 1995)	15
<i>Basic Inc. v. Levinson</i> , 485 U.S. 224 (1988)	6
<i>Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.</i> , 472 U.S. 559 (1985)	9
<i>Curtiss-Wright Corp. v. Schoonejongen</i> , 514 U.S. 73 (1995)	9
<i>Donovan v. Bierwirth</i> , 680 F.2d 263 (2d Cir. 1982)	10
<i>Eddy v. Colonial Life Ins. Co.</i> , 919 F.2d 747 (D.C. Cir. 1990)	14, 20, 21, 22
<i>Ehlmann v. Kaiser Foundation Health Plan, Inc.</i> , Docket No. 98-11020	1, 2, 3, 4
<i>Everson v. Blue Cross & Blue Shield</i> , 898 F. Supp. 532 (N.D. Ohio 1994)	25

Cited Authorities

Page

<i>Firestone Tire & Rubber Co. v. Bruch</i> , 489 U.S. 101 (1989)	9, 10
<i>Glaziers and Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Securities</i> , 93 F.3d 1171 (3d Cir. 1996)	22, 23
<i>Globe Woolen Co. v. Utica Gas & Electric Co.</i> , 224 N.Y. 483, 121 N.E. 378 (1918)	14, 22
<i>Greater New Orleans Broadcasting Ass'n., Inc. v. United States</i> , 119 S. Ct. 1923 (1999)	6
<i>Joyce v. RJR Nabisco Holdings Corp.</i> , 126 F.3d 166 (3d Cir. 1997)	22
<i>Lazorko v. Pennsylvania Hospital</i> , 1998 U.S. Dist. LEXIS 10062 (E.D. Pa. June 30, 1998)	
<i>Lowen v. Tower Asset Mgmt., Inc.</i> , 829 F.2d 1209 (2d Cir. 1987)	25
<i>Massachusetts Mutual Life Ins. v. Russell</i> , 473 U.S. 134 (1985)	9
<i>McConocha v. Blue Cross & Blue Shield</i> , 898 F. Supp. 545 (N.D. Ohio 1995)	25
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Cited Authorities

Page

<i>Nationwide Mutual Ins. Co. v. Darden</i> , 503 U.S. 318 (1992)	9
<i>New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.</i> , 514 U.S. 645 (1995)	28
<i>NLRB v. Amax Coal Co.</i> , 453 U.S. 322, 69 L. Ed. 2d 672, 101 S. Ct. 2789 (1981)	9, 10, 17
<i>Ries v. Humana Health Plan, Inc.</i> , 1995 WL 669583 (N.D. Ill. Nov. 8, 1995)	25, 26
<i>Shea v. Esensten</i> , 107 F.3d 625 (8 th Cir.), cert. denied, 139 L. Ed. 2d 229, 118 S. Ct. 297 (1997)	2, 3, 5, 19, 20, 21, 25
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	3, 8, 9, 14, 17, 19, 20, 28, 29
Statutes:	
29 U.S.C. § 1001, <i>et seq.</i>	1, 2, 4
29 U.S.C.A. § 1104	7, 11, 18, 24, 26, 29
29 U.S.C.A. § 1104(a)(1)	16, 19
29 U.S.C.A. § 1104(a)(1)(A)	26

Cited Authorities

Page

Rule:

United States Supreme Court Rule 37.6 1

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2 Legislative History of the Employee Retirement
Income Security Act of 1974, Ser. No. 93-406
(1976) 9

H.R. Conf. Rep. No. 93-1280 17

H.R. Rep. No. 93-533, 93rd Cong., 2d Sess. 36
(1974), *reprinted in* 1974 U.S.C.C.A.N. 4639 .. 9, 10

S. Rep. No. 93-383 (1973) 17

Restatement (Second) of Trusts § 2 cmt. (b) (1959)
..... 14

Restatement (Second) of Trusts § 170 cmt. (w)
(1992) 14

Restatement (Second) of Trusts § 170 cmt. 1(a)
(1959) 12

Restatement (Second) of Trusts § 170 cmt. 1(c) ... 12

Restatement (Second) of Trusts § 170 cmt. 1(o) .. 13

Restatement (Second) of Trusts § 170 cmt. 2(w) .. 13

Cited Authorities

Page

Restatement (Second) of Trusts § 170(1) (1957) .. 10

Restatement (Second) of Trusts § 173 cmt. d (1959)
..... 21

Restatement (Second) of Trusts, § 216 cmt. (k) ... 14

Restatement (Second) of Trusts, § 216(2) (1992) .. 13, 14

Restatement (Third) of Trusts, § 227 (1992) 17

Restatement (Third) of Trusts, § 227 cmt. (c) (1992)
..... 12, 13, 17

2 A. Scott, Law of Trusts § 170 (1967) 10, 11

G. Bogert & G. Bogert, Law of Trusts and Trustees
(rev. 2d ed. 1992) 9, 17, 29

INTEREST OF THE *AMICUS CURIAE*¹

Amicus curiae consists of beneficiaries of employee welfare benefit plans, protected by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.* *Amicus curiae* also subscribes to various national health maintenance organizations (HMOs) which, like the HMO in this case, have financial incentive arrangements with their physicians designed to minimize care. Currently pending before the Fifth Circuit Court of Appeals is a suit filed by *amicus curiae*, *Ehlmann v. Kaiser Foundation Health Plan, Inc.*, Docket No. 98-11020, Fifth Circuit Court of Appeals (fully briefed; oral argument heard October 5, 1999).² The *Ehlmann* Plaintiffs filed breach of ERISA fiduciary duty claims against various HMOs/ERISA fiduciaries based in part on the failure to disclose to the participants and beneficiaries of ERISA plans the material information that the HMOs impose financial incentives upon treating physicians.³

¹ Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amicus curiae*, contributed monetarily to the preparation and submission of this brief. The parties granted consent to the filing of this brief of *amicus curiae*; the letters of consent are being filed herewith.

² The individual plaintiffs in *Ehlmann* are Mary Ellen Ehlmann, Albert DeJohn, Carolyn Salters, Robert Whitacre, Sally Slagle, Carol and Jimmy Pressly, and Debra McDonald.

³ *Amicus curiae* respectfully suggests in the following discussion that *failure to disclose* material facts is the key element in a breach of ERISA fiduciary duty claim based on the existence of an HMO's financial incentives, a position closely aligned with the opinion of Judge Flaum's dissent from the Seventh Circuit's decision. See *Herdrich v. Pegram*, 154 F.3d 362, 380 (7th Cir. 1998).

The *Ehlmann* suit addresses the HMOs' breach of their ERISA fiduciary duties as ERISA plan administrators acting with discretionary authority. The ERISA fiduciary HMOs owe the ERISA plan members the traditional fiduciary duties of undivided loyalty under both ERISA and the common law of trusts. Yet, the *Ehlmann* Plaintiffs allege the HMOs seek to maximize the HMOs' profits as health care providers by giving doctors *undisclosed* incentives to deny or minimize medical care provided for ERISA plan members. Contrary to the ERISA beneficiaries' best interests, the ERISA patients are *uninformed* of the strong financial incentives which may influence, consciously or subconsciously, their physicians' diagnosis and recommended course of treatment by encouraging the physicians to provide the least costly, over the most appropriate, medical care. Accordingly, the *Ehlmann* Plaintiffs allege that the HMOs breach their ERISA fiduciary duties: the HMOs failed to disclose to participants that they established and implemented a financial incentive scheme at the expense of and in conflict with the interests of ERISA plan participants and beneficiaries. On the HMO defendants' motion, the district court dismissed the *Ehlmann* Plaintiffs' claims, finding that ERISA fiduciaries have no duty to disclose except as identified in the reporting and disclosure requirements for ERISA plan administrators, ERISA § 101, *et seq.*

On appeal, the *Ehlmann* Plaintiffs urged the Fifth Circuit to find that an HMO's ERISA fiduciary duties include a duty to disclose the material facts of an HMO's financial incentives, as found by the Eighth Circuit in *Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 118 S. Ct. 297 (1997).⁴ *Shea* determined that an HMO's imposition of financial incentives creates a danger to the plan participant's well being—a clear

⁴ *Shea* is discussed in greater detail in section II.B. below.

conflict between the interest of an ERISA plan participant, and the interest of the HMO's bottom-line—and that the HMO ERISA fiduciary's failure “to disclose [these] material facts affecting the participant's health care interests” rises to the level of a breach of ERISA fiduciary duty. *Shea*, 107 F.3d at 629.

If the Fifth Circuit rules in *Ehlmann* contrary to the Eighth Circuit's opinion in *Shea*, and in the absence of guidance from the Court clarifying the Seventh Circuit's determination in *Herdrich* that financial incentives give rise to an ERISA breach of fiduciary duty claim *upon the HMO's failure to disclose* material facts of the HMO's self-dealing financial incentive scheme, there will be a split in the circuits on the issue of an ERISA fiduciary's duty of disclosure.

To aid the Court in deciding the issues raised, *amicus curiae* files separately to emphasize the analysis for determining fiduciary duties under ERISA, which include the duty to disclose self-dealing, financial incentives resulting in conflicts of interest, as well as emphasizing the analysis for determining fiduciary status—as similarly examined by the Court in *Varity Corp. v. Howe*, 516 U.S. 489 (1996). Contrary to Petitioner HMO's cries of undermining managed care nationwide, affirming the Seventh Circuit's finding that financial incentives rise to the level of a breach of fiduciary duty—with the clarification that the breach of fiduciary duty occurs *when* the material facts of the *financial incentives are not disclosed* to participants and beneficiaries—ensures the fulfillment of the goals of Congress in enacting ERISA to protect employees participating in welfare benefit plans and allows HMOs to continue to use such “tools of managed care” which Petitioners seem so anxious to protect. Indeed, the position of Judge Flaum's dissenting opinion as urged by *amicus curiae* allows Petitioner HMO and other similarly situated HMOs to continue

utilizing financial incentives tied to treatment decisions—as long as fully disclosed—and protects the rights of ERISA participants and beneficiaries to be fully informed as Congress intended. 29 U.S.C. § 1001.

Amicus curiae files this brief because of an interest in aiding the Court in determining an issue affecting ERISA plan members nationwide who subscribe to HMOs utilizing financial incentive schemes. *Amicus curiae* has no direct financial or economic interest in the outcome of this suit other than their interest in the *Ehlmann* case which involves similar issues pending before the Fifth Circuit Court of Appeals. *Amicus curiae*—providing a perspective distinct from that of any party—proffers assistance through a detailed analysis applying the common law of trusts incorporated by Congress to determine the ERISA fiduciary duty issue presented herein.

SUMMARY OF ARGUMENT

The parties' arguments exemplify polarity: Respondent contends that the existence of Petitioners' financial incentives, alone and without more, supports a breach of ERISA fiduciary duty claim. Petitioners contend that their financial incentive structure does not precipitate a breach of ERISA fiduciary duty claim, and argue that a contrary opinion will signify the end of managed care as we know it. *Amicus curiae* respectfully suggests to the Court that neither extreme position argued by the parties is consistent with the goals of ERISA or with the principles of the law of trusts.⁵

⁵ *Amicus curiae*'s position does not foreclose the possibility that, as noted in Judge Flaum's dissenting opinion, financial incentives alone may support a breach of ERISA fiduciary duty claim in rare and acute circumstances. *Herdrich v. Pegram*, 154 F.3d 362, 384 (7th Cir. 1998).

Amicus curiae agrees with Judge Flaum's dissenting opinion that the mere existence of an asserted conflict of interest does not, "*without more*, give[] rise to a cause of action for breach of fiduciary duty under ERISA." *Herdrich v. Pegram*, 154 F.3d 362, 381 (7th Cir. 1998) (emphasis added).⁶ Following common law trust principles, the dissent wisely recognized that the essential element of an ERISA breach of fiduciary duty claim based on such financial incentive arrangements is an allegation that the fiduciary *failed to disclose* material facts of conflicts of interest to the participant or beneficiary, as found by the Eighth Circuit in *Shea*. *Herdrich*, 154 F.3d at 383 (citing *Shea v. Esenstein*, 107 F.3d 625 (8th Cir.), *cert. denied*, 139 L. Ed. 2d 229, 118 S. Ct. 297 (1997)) (emphasis added). "The complaint in the instant case ... never asserts that the plaintiff's health plan *failed to disclose* the financial incentives under which its physicians were operating." *Herdrich*, 154 F.3d at 383 n. 2 (emphasis added).

Recognizing that "dual loyalties are not per se unlawful" because "ERISA tolerates some conflict of interest on the part of fiduciaries," Judge Flaum opined that "market forces help reduce the risk that the fiduciary's conflict of interest in making coverage decisions will work to the detriment of the plan and the plan beneficiaries." *Id.* at 381. However, the dissent found that the role of the courts, to protect beneficiaries and enforce ERISA fiduciary duties, "is triggered when the market

⁶ Judge Flaum authored the opinion, cited and quoted herein, dissenting from the majority panel opinion in *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998). Judge Easterbrook, quoted extensively by Petitioners, authored the opinion dissenting from the denial of the petition for rehearing *en banc* in *Herdrich v. Pegram*, 170 F.3d 683 (7th Cir. 1999).

fails”—such as when information about the financial incentives are not disclosed to plan sponsors and beneficiaries.⁷ *Id.* at 383.

Urging an elaboration on Judge Flaum’s dissenting opinion rather than either more extreme position of the parties, *amicus curiae* presents an examination of ERISA’s legislative history and an application of trust law principles which reveals an ERISA fiduciary *duty to disclose*.⁸ The duty to disclose is

⁷ Unlike Judge Flaum’s dissenting opinion, J. Easterbrook’s market analysis fails to address or even acknowledge the element essential to insuring that market forces do indeed provide the desired protection for consumers/patients, i.e. full disclosure of material information—the sum and substance of *amicus curiae*’s position herein. The importance of material information being disseminated to the public is not a new concept but is one the Court has noted and discussed in other important market contexts. See *Basic Inc. v. Levinson*, 485 U.S. 224, 246 (1988) (citation omitted) (discussing the definition of “materiality” in the SEC context, the Court noted that “[j]ust as artificial manipulation tends to upset the true function of an open market, so the *hiding and secreting of important information obstructs the operation of the markets as indices of real value.*”) (emphasis added); *Greater New Orleans Broadcasting Ass’n., Inc. v. United States*, 119 S. Ct. 1923, 1930 (1999) (in determining that commercial speech conveying truthful information about lawful activities was entitled to First Amendment protections, the Court noted the importance of the dissemination of “accurate information as to the operation of market competitors, . . . which can benefit listeners by informing their consumption choices and fostering price competition.”). Consistent with the Court’s prior opinions recognizing the importance of disclosing complete and accurate material information, the position of *amicus curiae* allows Petitioner HMO, and other similarly situated HMOs in the health care market, to continue utilizing a favorite “tool of managed care”—physician financial incentives tied to treatment decisions—as long as the incentives are *disclosed* to ERISA members/patients.

⁸ Petitioner HMO specifically admits that, as an ERISA fiduciary, Petitioner HMO has the duty to disclose information to plan participants and beneficiaries as required under ERISA. Reply Brief of Petitioners at

triggered when a self-dealing financial incentive scheme, such as at issue here, gives rise to conflicts of interest involving an ERISA fiduciary. Petitioners admit occupying the dual roles of ERISA fiduciaries (Reply Brief of Petitioners at 6-7, *Pegram v. Herdrich*, 120 S. Ct. 10 (1999) (No. 98-1949)) and for-profit health care providers (Petition for Writ of Certiorari at 3-4, *Pegram v. Herdrich*, 120 S. Ct. 10 (1999) (No. 98-1949)), and do not deny the conflicts of interest resulting from Petitioner HMO’s self-dealing, physician financial incentives as alleged by Respondent Patient. Common law trust principles, which legislative history shows Congress adopted to aid in defining the broad fiduciary duties in ERISA § 404, explain that the only way Petitioner HMO may avoid a breach of ERISA fiduciary duty claim based on conflicts of interest is through *disclosure* of the material facts—the strong financial incentives to physicians to give less care—to ERISA plan participants and beneficiaries.

The problem resulting from the conflict of interest arising out of Petitioner HMO’s dual roles is clear: although ERISA plan assets are used to implement the financial incentive arrangements, the benefits and profits flowing from the “success” of the financial incentive scheme go to Petitioner HMO as a health care provider, not to the Plan. Indeed, contrary to the interests of participants and beneficiaries, Petitioners’ financial incentive structure is designed to minimize health care and maximize profits and bonuses to Petitioners as health care providers. Such conflicts of interest necessarily

⁷ (in response to Respondent’s original Count III, “in which she asserted that Carle Clinic *failed to disclose* certain material facts, . . . Petitioners freely acknowledge[d] that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, e.g., when they provide information to participants as required under ERISA and when they make decisions about who is eligible for plan benefits.”).

trigger Petitioner HMO's ERISA fiduciary duty to disclose the material facts regarding the financial incentive arrangements.

Petitioners' argument does not address the essential "disclosure" element of an ERISA breach of fiduciary duty claim based on HMO financial incentive arrangements. Rather, Petitioners attempt to divert the Court's focus by creating a new issue: in which role—ERISA fiduciary or health care provider—does Petitioner HMO act when implementing the financial incentive scheme? Petitioners ignore the conflicts of interest resulting from Petitioner HMO's self-dealing in the implementation of the financial incentives—the conflicts of interest which compel disclosure of material facts to the ERISA plan participants and beneficiaries. Following the guidance of *Varity Corp.*, disclosure of such material information is a fiduciary activity in the discharge of fiduciary duties under ERISA and the common law of trusts, regardless of which hat Petitioner HMO wears when implementing the financial incentives. *Varity Corp.*, 516 U.S. at 502-503.

Amicus curiae respectfully suggests that the Court affirm the Seventh Circuit's reversal of the district court's dismissal of Respondent Patient's claim on the ground that a claim for breach of ERISA fiduciary duty may arise out of financial incentive arrangements *when the HMO/fiduciary fails to disclose* the material facts of the resulting conflicts of interest. Upon the issuance of this Court's opinion providing clear guidance regarding breach of ERISA fiduciary duty allegations based on the non-disclosure of conflicts of interest arising out of self-dealing, financial incentive schemes utilized by HMO/ERISA fiduciaries, *amicus curiae* respectfully suggests that Respondent be given the opportunity to replead to include the essential element of failure to disclose, to the extent allowed under the Federal Rules of Civil Procedure.

ARGUMENT

I. ERISA's legislative history shows that common law trust principles provide the key element of an ERISA breach of fiduciary duty claim arising out of fiduciary conflicts of interest: non-disclosure of material facts.

In addition to "codif[ying] and mak[ing] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts," Congress deliberately drafted expansive, nonspecific language of ERISA "invok[ing] the common law of trusts to define the general scope of their authority and responsibility." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (quoting H. R. Rep. No. 93-533, p. 11 (1973)) (referring to Restatement of Trusts regarding proper standard of review for fiduciary/administrator benefit denial); *Varity Corp.*, 516 U.S. at 496 (referring to Restatement of Trusts to determine whether activities were employer or fiduciary/administrator).⁹

⁹ Referencing *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985); H.R. Rep. No. 93-533, pp. 3-5, 11-13 (1973), 2 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled for the Senate Subcommittee on Labor and Public Welfare by the Library of Congress), Ser. No. 93-406, pp. 2350-2352, 2358-2360 (1976) (hereinafter Leg. Hist.); G. Bogert & G. Bogert, *Law of Trusts and Trustees* § 255, p. 343 (rev. 2d ed. 1992). See also *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995) (referring to the Restatement of Trusts to determine propriety of plan amendment); *NLRB v. Amax Coal Co.*, 453 U.S. 322 (1981) (referring to the common law of trusts and noting that ERISA codified strict fiduciary standards); *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318 (1992) (referring to Restatement of Agency to construe the term "employee" in ERISA); *Massachusetts Mutual Life Ins. v. Russell*, 473 U.S. 134 (1985) (concurring opinion referring to

The principles of fiduciary conduct are adopted from existing trust law, but with modifications appropriate for employee benefit plans. These salient principles place a twofold duty on every fiduciary: to act in his relationship to the plan's fund as a prudent man ..., and to act consistently with the principles of administering the trust for the exclusive purposes previously enumerated....

H.R. Rep. No. 93-533, 93rd Cong., 2d Sess. 36 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4651.

"ERISA abounds with the language and terminology of trust law," such as "fiduciary" and "administration." *Firestone*, 489 U.S. at 110. Analysis of a "fiduciary" under ERISA and common law trust principles shows that Petitioner HMO is an ERISA fiduciary in connection with the "administration" of the ERISA plan which includes a duty of loyalty owed to Respondent Patient. Trust principles also show that, as an ERISA fiduciary, Petitioner HMO's self-dealing—implementing physician financial incentives designed to increase HMO profits—and the resulting conflicts of interest give rise to the ERISA fiduciary duty to disclose material information to participants and beneficiaries, even absent inquiry.

As does any fiduciary, "[u]nder principles of equity, a [fiduciary of an ERISA plan] bears an unwavering duty of complete loyalty to the beneficiary of the trust, *to the exclusion of the interests of all other parties.*" *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329 (1981) (citing Restatement (Second) of Trusts § 170(1) (1957); 2 A. Scott, Law of Trusts § 170

Restatement of Trusts for guiding principles of fiduciary conduct and determining available remedies).

(1967)) (emphasis added). This broad-based fiduciary duty finds its statutory expression in section 404 of ERISA:

(a) Prudent man standard of care.

(1) . . . a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries [the duty of loyalty "derived from the common law of trusts," *Central States*, 472 U.S. 570-571]; and . . .

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims....[the standard of care "derived from the common law of trusts," *Central States*, 472 U.S. 570-571]

ERISA § 404, 29 U.S.C. § 1104.

The touchstone of an ERISA fiduciary's duty was properly summarized by the court below as follows:

The requirement that an ERISA fiduciary act "with an eye single to the interests of the participants and beneficiaries," *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982), is

the most fundamental of his or her duties, and "must be enforced with uncompromising rigidity." *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-30, 101 S. Ct. 2789, 2794-96, 69 L. Ed. 2d 672 (1981) (citation and internal quotation omitted).

Herdrich, 154 F.3d at 371.

Trust law, of course, supplies extensive guidance regarding appropriate and necessary conduct of ERISA fiduciaries fulfilling their duty of loyalty.

The strict duty of loyalty in the trust law ordinarily prohibits the trustee from investing or managing trust investments in a manner that will give rise to a personal *conflict of interest*.

Restatement (Third) of Trusts, § 227 cmt. (c) (1992) (emphasis added). The Restatement (Second) of Trusts identifies examples of prohibited conflicts of interests:

- a fiduciary may "not profit at the expense of the beneficiary . . . without his *consent*" (Restatement (Second) of Trusts § 170 cmt. 1(a) (1959) (emphasis added);
- a fiduciary violates his duty of loyalty "where he has a *personal interest* in the purchase [of trust property] of such a substantial nature that it might *affect his judgment*" (*Id.*, cmt. 1(c)) (emphasis added);

- a beneficiary cannot avoid a fiduciary's acquiring an interest in trust property if the beneficiary *knows all material facts* that the fiduciary knows or should know (*Id.*, cmt. 2(w)) (emphasis added); and
- a fiduciary may not "accept for himself from a third person any bonus or commission for any act done by him in connection with the administration of the trust Where a trustee . . . uses his power as shareholder to make an *improper* profit, he is liable for the profit made so." *Id.*, cmt. 1(o) (emphasis added).

However, the Restatement allows certain conflicts of interest *if* the fiduciary gains consent of the beneficiary after *full disclosure of all material facts*. Restatement (Third) of Trusts, § 227 cmt. (c) (1992).

The prohibition [of investments giving rise to a conflict of interest] also applies to investing in a manner that is intended to serve interests other than those of the beneficiaries

. . . Such considerations, however, may properly influence the investment decisions of a trustee to the extent permitted by . . . consent of the beneficiaries.

Id. (internal citation omitted). A beneficiary's consent is effective only if the beneficiary knows "the material facts which the trustee knew or should have known." Restatement (Second) of Trusts § 216(2) (1992).

The ERISA fiduciary duty of loyalty thus encompasses a duty to disclose where Petitioner HMO implements the financial incentive arrangements with physicians, serving the interests of Petitioner HMO, in conflict with the interests of the participants and beneficiaries. The duty to disclose requires Petitioner HMO to "inform the beneficiary of . . . the material facts . . . [and] see that the beneficiary is sufficiently informed so that he understands the character of the transaction." *Id.* § 216 cmt. (k). Indeed, if the fiduciary does not disclose the material facts to the beneficiary, the fiduciary may be held liable for a breach of trust. *Id.* § 216(2) (1992).¹⁰

Disclosure by Petitioner HMO, even absent inquiry, is essential because "[a] beneficiary, about to plunge into a ruinous course of dealing, may be betrayed by silence as well as by the spoken word." *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 751 (D.C. Cir. 1990) (quoting *Globe Woolen Co. v. Utica Gas & Electric Co.*, 224 N.Y. 483, 489, 121 N.E. 378, 380 (1918) (Cardozo, J.)). In other words, an HMO/ERISA fiduciary's silence—non-disclosure—deceives beneficiaries who blindly trust and rely upon their physicians' treatment decisions and recommendations because they were not informed of the material facts that their treating physicians' judgment may be affected by the financial incentives imposed by the HMO. Silence that deceives "a plan's beneficiaries in order to save [Petitioner HMO] money at the beneficiaries' expense is not to act 'solely in the interest of the participants and beneficiaries.'" *Varity Corp.*, 516 U.S. at 506.

Thus, Petitioner HMO's use of ERISA plan assets to implement physician financial incentives gives rise to conflicting

¹⁰ See also Restatement (Second) of Trusts, § 2 cmt. (b) (1959); § 170 cmt. (w) (1992).

loyalties—the duty owed to ERISA plan members to act *solely* in their interest, and the loyalty it owes to its own bottom-line—which trust principles dictate must be disclosed in the discharge of Petitioner HMO's ERISA fiduciary duties, even absent inquiry.

II. Petitioners' dual roles as ERISA fiduciaries and health care providers (or "arrangers of care") give rise to conflicts of interest that must be disclosed to avoid a breach of ERISA fiduciary duty claim.

A. Conflicts of interest arise with Petitioner HMO acting in the dual roles of health care provider and ERISA plan fiduciary.¹¹

A brief discussion of the dual roles of Petitioner HMO is helpful for two reasons: (1) it defines and establishes the conflicts of interest alleged, and (2) it emphasizes the impact of such conflicts and the importance of disclosure of the HMO's physician financial incentives to ERISA plan participants and beneficiaries such as Respondent Patient.

First, as provider, Petitioner HMO arranges for health care benefits to be provided through Carle Clinic Association and other participating providers. Petition for Writ of Certiorari at 3. Petitioner HMO implemented a financial "incentive scheme, which invited and encouraged plan fiduciaries to place

¹¹ See *Bailey v. Blue Cross/Blue Shield of Va.*, 866 F. Supp. 277, 279 (E.D. Va. 1994), *aff'd*, 67 F.3d 53 (4th Cir. 1995) (citing the Fourth Circuit for principle that an ERISA plan administrator occupying dual roles of ERISA fiduciary and plan health care provider acts under a conflict of interest, and thus applying lower level of deference to HMO's discretionary interpretation of group-insurance contract when reviewing HMO's decision to deny benefits).

their own interests ahead of the interests of plan beneficiaries.” *Herdrich*, 154 F.3d at 372. Because Petitioner HMO’s compensation arrangements with the physician providers were calculated “based on the difference between total plan costs . . . and revenues . . . , an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure large bonuses.” *Id.* Put simply, the less care provided to ERISA plan members, the more profit Petitioners stand to make.

Second, as a fiduciary to the ERISA plan for which health care and administration of health care benefits is provided, Petitioner HMO manages the ERISA plan assets on behalf of ERISA plan participants and beneficiaries. Petition for Writ of Certiorari, Petitioners’ Appendix 85a, *Pegram v. Herdrich*, 120 S. Ct. 10 (1999) (No. 98-1949). As fiduciary and plan administrator, in the exercise of discretionary authority, control, and responsibility in the plans’ administration and management of plan property and assets, Petitioner HMO is obliged to act “solely in the interest of the participants and beneficiaries.” Petitioners’ Appendix 85a; ERISA § 404(a)(1).

Petitioners do not address the Seventh Circuit’s discussion of or Respondent Patient’s allegations showing conflicts of interest arising from Petitioner HMO’s dual roles: (1) ERISA fiduciary administering the ERISA plan, and (2) health care provider (or arranger of health care) implementing financial incentives. Petitioners argue that because ERISA contemplates fiduciaries occupying dual roles, and because their financial arrangements with the physicians are specifically allowed, the mere fact of the financial incentives cannot support a breach of ERISA fiduciary duty claim. Petitioners’ argument ignores, however, that tolerance does not give fiduciaries unfettered freedom to engage in transactions encumbered with conflicts of interest *in the absence of proper disclosure to*

participants and beneficiaries. See Restatement (Third) of Trusts, § 227 (1992).

In *Varity*, the Court recognized that certain conflicts of interest (i.e. dual roles) are countenanced under ERISA where a fiduciary is both “an employer and the benefit plan’s administrator,” however, the Court also noted an earlier opinion discussing the tenet that the “common law of trusts prohibits fiduciaries from holding positions that create conflict of interest with trust beneficiaries.” *Varity*, 516 U.S. at 498 (citing *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-330, 69 L. Ed. 2d 672, 101 S. Ct. 2789 (1981), *Bogert & Bogert*, supra, § 543, at 218, 264 (same)). In *NLRB*, the Court stated not only that ERISA codifies “strict fiduciary standards” but also that

[t]he legislative history of ERISA confirms that Congress intended in particular to prevent trustees “from engaging in actions where there would be a conflict of interest with the fund, such as representing any party dealing with the fund.” In short, the fiduciary provisions of ERISA were designed to prevent a trustee “*from being put into a position where he has dual loyalties, and, therefore, he cannot act exclusively for the benefit of a plan’s participants and beneficiaries.*”

NLRB, 453 U.S. at 333-34 (quoting S. Rep. No. 93-383, pp. 31, 32 (1973); H. R. Conf. Rep. No. 93-1280, supra, at 309. n17) (emphasis added). Applying common law trust principles to define ERISA’s exacting standards of fiduciary loyalty and its concomitant requirement of exclusive devotion to ERISA plan members, a breach of ERISA fiduciary duty claim arises out of Petitioner HMO’s divided interests and dual loyalties *when*

Petitioner HMO fails to disclose the material facts of the conflicts of interest.

B. Case law consistently upholds ERISA section 404's broad fiduciary duty of loyalty, including the fiduciary duty to disclose material information for the protection of ERISA plan participants and beneficiaries.

Even absent inquiry, an ERISA fiduciary's failure to disclose material information—here, the conflicts of interest arising out of Petitioner HMO's self-dealing compensation system that rewards both the HMO and doctors for dispensing as little health care as possible—breaches section 404's duty of utmost loyalty. That it is material to an ERISA plan member to know the details of conflicts of interest arising out of a financial system that rewards doctors who minimize health care and punishes doctors who provide adequate treatment and testing is self-evident. Indeed in the instant case, when Respondent Patient was required to wait eight days for a necessary diagnostic procedure to be performed at Petitioner HMO's own facility more than fifty miles away, had Respondent Patient known the facts regarding Petitioner HMO's financial incentive arrangements designed to minimize care and maximize profits, Respondent Patient would have been in an informed position to question the physician's orders or seek earlier, preventive testing and treatment on her own.

The materiality of this information also finds support in several circuit court and district court opinions which *amicus curiae* discuss as instructive on the issue of an HMO/ERISA fiduciary's duty to disclose material information—an HMO's physician financial incentives—relating to an HMO's conflicts of interest in the absence of such Supreme Court precedent.

Although not the first circuit to recognize a general fiduciary duty to disclose material information to ERISA plan members, the Eighth Circuit recently applied that duty to a claim alleging facts establishing nearly identical conflicts of interest as Respondent Patient alleged in Count III. In *Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 118 S.Ct. 297 (1997), the Eighth Circuit held that the HMO defendants, as ERISA fiduciaries, were required to disclose all material facts, including their payment of incentives to physicians to delay or deny health care. *Id.* at 628-29. The *Shea* plaintiff claimed—successfully for purposes of defeating a dismissal motion—that the HMO breached its fiduciary duty under section 404(a)(1) of ERISA to disclose to ERISA plan members that the HMO paid financial incentives designed to minimize treatment referrals by primary-care doctors. *Id.* at 627.

In *Shea*, despite an obvious need based on family history and symptoms, a covered plan member was unable to obtain a referral from his primary-care physician to a cardiologist; he later died of heart failure. As does Petitioner HMO here,¹² the *Shea* HMO had contracts with its doctors that contained financial incentives designed to minimize referrals. The Eighth Circuit properly applied common law trust principles and found that the HMO, as an ERISA fiduciary, had a duty to disclose the existence of these financial disincentives to all members of ERISA plan, including Mr. Shea. *Shea*, 107 F.3d at 628-29.

The *Shea* court first noted that the Court's opinion in *Varity Corp.* "concluded that ERISA fiduciaries must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members." *Id.* at 628. In turn, that duty of loyalty includes the requirement

¹² Petitioners' Appendix 86a.

that an ERISA fiduciary “communicate any material facts which could adversely affect a plan member’s interest.” *Id.* As the court pointed out, “the duty to disclose material information is the core of a fiduciary’s responsibility, animating the common law of trusts long before the enactment of ERISA.” *Id.* (quoting *Eddy v. Colonial Life Ins. Co. of America*, 919 F.2d 747, 750 (D.C. Cir. 1990)). With regard to the specific claim before it, the *Shea* court observed that

a financial incentive scheme put in place to influence a treating doctor’s referral practices when the patient needs specialized care *is certainly a material piece of information*. This kind of patient necessarily relies on the doctor’s advice about treatment options, and *the patient must know* whether the advice is influenced by self-serving financial considerations[—conflicts of interest—]created by the health insurance provider.

Id. (emphasis added).

As in *Shea*, the silence of Petitioner HMO as an ERISA fiduciary creates a danger to all plan members who may seek or receive health care through Petitioner HMO’s managed care system—a system that trusting participant and beneficiary patients do not know is designed to enhance Petitioners’ profits. In short,

when an HMO’s financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, *the incentives must be*

disclosed and the failure to do so is a breach of ERISA’s fiduciary duties.

Shea, 107 F.3d at 629 (emphasis added).

Though not involving HMO financial incentives, the first circuit to recognize an ERISA fiduciary’s duty to disclose material information affecting a beneficiary was the District of Columbia Circuit in *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 751 (D.C. Cir. 1990). There, the court held that the failure to give complete and correct material information at a beneficiary’s request—and in some circumstances upon the fiduciary’s *own initiative*—was a breach of fiduciary duty. *Id.* at 750. Not restricting its holding to a direct inquiry by plan beneficiaries, the *Eddy* court noted the fiduciary duty as stated in the Restatement (Second) of Trusts:

[The trustee] is under a duty to communicate to the beneficiary material facts affecting the interests of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection in dealing with a third person

Id. (citing Restatement (Second) of Trusts § 173 cmt. d (1959)). And quoting Justice Cardozo, the *Eddy* court concluded—in words applicable here as well—

“The [fiduciary] is free to stand aloof, while others act, if all is equitable and fair. He cannot rid himself of the duty to warn and to denounce, if there is improvidence or oppression, either apparent on the surface or lurking beneath the surface, but visible to his practiced eye.”

Eddy, 919 F.2d at 752 (quoting Judge Cardozo in *Globe Woolen Co. v. Utica Gas & Electric Co.*, 224 N.Y. 483, 489, 121 N.E. 378, 380 (1918)).

In *Anweiler*, another Seventh Circuit case positing a broad disclosure duty even absent participant inquiry (although ultimately holding that the plaintiff could not recover equitable relief because of an “unclean hands” defense), the court agreed that an ERISA fiduciary breached its duty of loyalty by not giving an insured “full and complete material information” concerning a reimbursement agreement. *Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986 (7th Cir. 1992). More broadly, though, the court noted that a duty of disclosure “exists when a beneficiary asks fiduciaries for information, and even when he or she does not.” *Id.* at 991 (citing *Eddy*, 919 F.2d at 750) (emphasis added).

This principle has been applied in the Third Circuit as well: In *Glaziers and Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Securities*, 93 F.3d 1171, 1182 (3d Cir. 1996), the court found that a fiduciary has a legal duty to disclose material facts unknown by the plan member, beneficiary, or participant, but known by the fiduciary and which the beneficiary must know for its own protection. Such a duty need not be triggered by a request for information directed to the fiduciary; rather, certain circumstances known by the fiduciary can give rise to an affirmative duty to disclose—indeed, “absent such information, the beneficiary may have no reason to suspect that it should make inquiry into what may appear to be a routine matter.” *Id.* at 1181.¹³

¹³ See also *Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 174 (3d Cir. 1997) (fiduciary duty to provide complete and accurate information to participants and beneficiaries “extends beyond just

Referring to congressional intent that ERISA’s fiduciary provisions incorporate general trust principles, the *Glaziers* court stated:

Under the common law of trusts, a fiduciary has a fundamental duty to furnish information to a beneficiary. “This duty to inform is a constant thread in the relationship between beneficiary and trustee; it entails not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence might be harmful.”

Id. at 1180 (citations omitted).

Consistent with *Glaziers* and similar cases, the Fifth Circuit too has imposed a duty to disclose material information upon ERISA fiduciaries, even absent a direct inquiry from a plan participant or beneficiary. In *McDonald v. Provident Indemnity Life Insurance Company*, 60 F.3d 234 (5th Cir. 1995), an ERISA fiduciary of the plaintiff’s benefit plan learned of material information regarding prohibitively escalating premiums for small employers such as McDonald Equipment, but failed to disclose that information to either the employer or the beneficiaries. As a result, the company was forced to let its insurance coverage lapse.

Although affirming a judgment for the defendant because McDonald failed to establish a prima facie case of loss to the plan as a whole (a finding in the appeals court not challenged by Petitioners in this case), the Fifth Circuit nonetheless found that the ERISA fiduciary had an obligation

responding to requests about specific benefits”).

under section 404 to disclose the material facts concerning a rating schedule for group-health-coverage premiums. *Id.* at 237. The court did *not* find that the duty to disclose is triggered only upon inquiry by a plan beneficiary, but rather noted that “[s]ection 404(a) imposes on a fiduciary the duty of undivided loyalty to plan participants and beneficiaries,” in addition to a duty to exercise “care, skill, prudence and diligence.” An “obvious component of those responsibilities,” the *McDonald* court noted, is the “duty to disclose material information.” *Id.*

In short, applicable case law applying common law trust principles reveals the obvious: occupying dual roles, Petitioner HMO creates and operates under conflicts of interest and, unless Petitioner HMO voluntarily discloses the material facts of the financial incentive structure designed to minimize health care and maximize Petitioner HMO’s profits, Petitioner HMO breaches the ERISA fiduciary duty of loyalty.

- C. *The Seventh Circuit’s finding that the financial incentive arrangements implemented by Petitioner HMO give rise to an ERISA breach of fiduciary duty claim should be affirmed with the clarification that the breach occurs in the absence of full disclosure by an ERISA fiduciary.*

The Seventh Circuit properly held that while a financial incentive scheme’s mere existence does not *automatically* show a breach of fiduciary duty, the implementation of such a scheme can indeed give rise to a breach of ERISA fiduciary duty claim. *Herdrich*, 154 F.3d at 373. The appeals court thus properly reversed the Rule 12(b)(6) dismissal of Respondent Patient’s case.

The appeals court properly began the analysis by observing that “[a] fiduciary breaches its duty of care . . . whenever it acts to benefit its own interests.” *Id.* at 371. That duty, the appeals court noted, is “directed particularly at schemes ‘tainted by a conflict of interest and thus highly susceptible to self dealing.’” *Id.* (quoting *Lowen v. Tower Asset Mgmt., Inc.*, 829 F.2d 1209, 1213 (2d Cir. 1987)). In addition to noting the holdings of *Shea* and *Anweiler* (discussed in section II.B. above), the Seventh Circuit found *Ries v. Humana Health Plan, Inc.*, 1995 WL 669583 (N.D. Ill. Nov. 8, 1995), instructive on the conflict-of-interest issue.

In *Ries*, the defendant health plan, which paid 80% of costs, imposed a subrogation arrangement on its participants, routinely collecting full reimbursement from its participants while at the same time secretly negotiating substantial discounts for its own share of the charges in the first place. Plan members were thus paying more than 20% of the amounts received by the hospitals, and Humana was recouping an effective bonus for itself by paying undisclosed discounted amounts less than 80% of the costs of covered medical expenses.

The *Ries* court held that ERISA did not “permit a plan insurer to recoup more from its insureds than it actually pays out on their behalf under the terms of *undisclosed* discounting arrangements with health care providers.” *Id.* at *2 (emphasis added). The court supported this holding by citing an Ohio district court’s opinions in *Everson v. Blue Cross & Blue Shield*, 898 F. Supp. 532 (N.D. Ohio 1994), and *McConocha v. Blue Cross & Blue Shield*, 898 F. Supp. 545 (N.D. Ohio 1995), in which that court held that “a plan insurer’s *undisclosed* practice of obtaining discounts from health care providers and failing to pass on a proportionate share of the discounts violated” ERISA’s fiduciary duties. *Ries*, 1995 WL

669583 at *3 (emphasis added). According to *Ries*, it is this type of "secret self-enhancement" that causes a fiduciary to violate its obligation under section 404. *Id.* Agreeing with the Ohio district court, the *Ries* court held flatly that "[a] fiduciary breaches its duty of loyalty under section 1104(a)(1)(A) [section 404] whenever it acts to benefit its own interests." *Id.* at *7.

In a phrase particularly applicable to the instant case, the *Ries* court went on to hold that a fiduciary's

covert profiteering at the expense of insureds is inconsistent with its duties of acting 'solely in the interest of the participants and beneficiaries' . . . and of refraining from engaging in self-dealing.

Id. (quoting ERISA § 404(a)(1)(A)).

As Respondent Patient alleged: Petitioner HMO wrongfully self-deals by seeking to maximize HMO profits through the financial-incentive scheme. Petitioners' Appendix 85a-87a. The appeals court below had little difficulty in concluding that a conflict of interest might be present in the challenged arrangement:

[a]n incentive existed for [doctors] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, *it is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.*

Id. at 372 (emphasis added).

The appeals court was careful to recognize that although ERISA may allow fiduciaries to adopt dual loyalties,

the tolerance of dual loyalties does not extend to [a situation] where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of 'loyalty' to his own financial interests. Tolerance, in other words, has its limits.

Id. at 373. However, the court of appeals stopped short of insisting on allegations showing the absence of the proper course of action for an ERISA fiduciary operating in the dual capacity of fiduciary and for-profit health care provider: *disclosure* of the conflict of interest to the participants and beneficiaries. Thus, with the clarification that a breach of ERISA fiduciary duty based on HMO financial incentives occurs *in the absence of full disclosure* by the HMO/ERISA fiduciary, the Seventh Circuit is properly affirmed.

III. Petitioner HMO's argument that it implements the financial incentive arrangements in its health care provider role misses the point: conflicts of interest arise out of self-dealing financial incentives that, in its ERISA fiduciary role, Petitioner HMO must disclose or there is a breach of ERISA's broad fiduciary duties.

The following discussion proceeds on the understanding that Petitioners' financial incentive structure pays increased profits and bonuses to the physicians. However, if Petitioners' assert that the benefits of the financial incentives are paid and

reaped only at the provider level, then ERISA is not implicated at all, and this suit should not be in federal court but in state court proceeding on pure state-law, quality of health care issues addressing the effects of the financial incentives on the health care provided. See *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

Even if Petitioner HMO implements financial incentive arrangements in its health care provider role, Petitioner HMO's self-dealing requires Petitioner HMO to act in its ERISA fiduciary role to avoid the evils inherent in the resulting conflicts of interest through full disclosure of the material facts, as discussed in Sections I and II above. Here, Petitioner HMO acts as an ERISA fiduciary administering an ERISA plan when, under competing interests *and without disclosure*, financial incentives are paid out of ERISA plan assets to reward physicians for providing minimal care. Such "administration" of an ERISA plan (a trust) and the failure to disclose the conflict of interests arising out of a self-dealing financial incentive scheme implemented with ERISA plan assets clearly falls within the category of a fiduciary act under *Varity Corp.*

In *Varity Corp.*, the Court directed that the determination of whether a defendant's actions "fall within the statutory definition of 'fiduciary' acts," is achieved by looking "to the common law, which, over the years has given to terms such as 'fiduciary' and trust 'administration' a legal meaning to which, we normally presume, Congress meant to refer." *Varity Corp.*, 516 U.S. at 502 (citation omitted).

There is more to plan (or trust) administration than simply complying with the specific duties imposed by the plan documents or statutory regime; it also includes the activities that are

'ordinary and natural means' of achieving the 'objective' of the plan. Indeed, the primary function of the fiduciary duty is to constrain the exercise of discretionary powers which are controlled by no other specific duty imposed by the trust instrument or the legal regime. If the fiduciary duty applied to nothing more than activities already controlled by other specific legal duties, it would serve no purpose.

Varity Corp., 516 U.S. at 504 (citing *Bogert & Bogert, supra*, § 551, at 41-52). Indeed, the Court found that

[c]onveying information about the likely future of plan benefits, thereby permitting beneficiaries to make an informed choice about continued participation, would certainly seem to be an exercise of a power 'appropriate' to carrying out an important plan purpose.

Varity Corp., 516 U.S. at 502 (conclusion from discussion of the law of trusts) (emphasis added).

Likewise, "disclosure" of the financial incentives in the administration of the ERISA plan is certainly an "ordinary and natural means" for Petitioner HMO to discharge its ERISA fiduciary duties "solely in the interest of the participants and beneficiaries," and "achiev[e] the 'objective' of the plan"—to provide health care "benefits to participants and their beneficiaries." *Varity Corp.*, 516 U.S. at 504; 29 U.S.C.A. § 1104. The Court's discussion in *Varity Corp.* shows that, more than merely determining coverage of benefits and the proper course of treatment as provided in the plan documents, "administration" of the ERISA plan encompasses Petitioner

HMO's duty to disclose the material facts of the financial incentives creating conflicts of interest.

CONCLUSION

Common law trust principles, applied as ERISA legislative history intended, establish that conflicts of interests in Petitioner HMO's intertwined dual roles of ERISA fiduciary and health care provider give rise to a claim for breach of fiduciary duty *in the absence of full disclosure* of the financial incentive arrangements. Accordingly, the Seventh Circuit's reversal of the district court's dismissal of Respondent Patient's claim on the grounds that a claim for breach of ERISA fiduciary duty may arise out of a financial incentive scheme is properly affirmed with the added clarification that the breach occurs in the absence of full disclosure of material facts regarding conflicts of interest necessarily resulting from the implementation of the financial incentive arrangements.

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22

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Supreme Court of the United States

Lori Pegram,

Petitioner,

v.

CYNTHIA HERDRICH,

Respondent.

On Writ of Certiorari
To the United States Court of Appeals
For the Seventh Circuit

**BRIEF OF THE STATES OF ILLINOIS,
CALIFORNIA, DELAWARE, FLORIDA, IOWA,
MASSACHUSETTS, MISSISSIPPI, MISSOURI,
MONTANA, NEVADA, NEW JERSEY, NORTH
CAROLINA, OHIO, OKLAHOMA, PENNSYLVANIA,
RHODE ISLAND, TENNESSEE AND TEXAS AS
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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE <i>AMICI CURIAE</i>	1
SUMMARY OF ARGUMENT	2
ARGUMENT	6
I. HMOs ARE NOT ERISA PLANS--THEY ARE HEALTHCARE BUSINESSES THAT SELL PRODUCTS AND SERVICES	6
A. The ERISA Plan and Benefit	8
B. HMO Services and Plan Administration ...	11
II. THE ORIGINAL COUNT III IS NOT PREEMPTED BY ERISA	16
III. RESPONDENT STATES AN ERISA CLAIM WHEN SHE PLEADS THAT HMO BENEFIT DETERMINATIONS IN ADMINISTRATION OF THE PLAN WERE BASED ON THE HMO'S OWN FINANCIAL INTERESTS	23
CONCLUSION	27

TABLE OF AUTHORITIES

	Page
CASES:	
<i>American Drug Stores, Inc., v. Harvard Pilgrim Health Care, Inc.,</i> 973 F.Supp. 60 (D. Mass. 1997)	13-15
<i>Anderson v. Humana, Inc.,</i> 24 F.3d 889 (7th Cir. 1994)	20, 21
<i>Arizona State Carpenters Pension Trust Fund v. Citibank,</i> 125 F.3d 715 (9th Cir. 1997)	12
<i>Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.,</i> 187 F.3d 1045 (9th Cir. 1999)	22
<i>Cipollone v. Liggett Group,</i> 505 U.S. 504 (1992)	18
<i>Conley v. Gibson,</i> 355 U.S. 41 (1957)	23
<i>Coyne & Delany Co. v. Selman,</i> 98 F.3d 1457 (4th Cir. 1996)	22
<i>Curtiss-Wright Corp. v. Schoonejongen,</i> 514 U.S. 73 (1995)	2
<i>Custer v. Sweeney,</i> 89 F.3d 1156 (4th Cir. 1996)	12
<i>De Buono v. NYSA-ILA Medical & Clinical Serv. Fund,</i> 520 U.S. 806 (1997)	Passim

<i>Donovan v. Bierwirth,</i> 680 F.2d 263 (2d Cir.), cert. denied, 459 U.S. 1069 (1982)	25
<i>Donovan v. Dillingham,</i> 688 F.2d 1367 (11th Cir. 1982)	8
<i>Dukes v. U.S. Healthcare, Inc.,</i> 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995)	16, 24
<i>Engelhardt v. Paul Revere Life Ins. Co.,</i> 139 F.3d 1346 (11th Cir. 1998)	16
<i>Fort Halifax Packing Co, Inc. v. Coyne,</i> 482 U.S. 1 (1987)	9, 16
<i>Herdrich v. Pegram,</i> 154 F.3d 362 (7th Cir. 1998)	24
<i>Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.,</i> 944 F.2d 752 (10th Cir. 1991)	12
<i>Hughes Aircraft Co. v. Jacobson,</i> 525 U.S. 432 (1999)	16
<i>In re U.S. Healthcare, Inc.,</i> 193 F.3d 151 (3rd Cir. 1999)	15, 22
<i>Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.,</i> 519 U.S. 316 (1997)	21
<i>Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio,</i> 982 F.2d 1031 (6th Cir.), cert. denied, 510 U.S. 819 (1993)	16

<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996)	16
<i>Lupo v. Human Affairs Intern., Inc.</i> , 28 F.3d 269 (2d Cir. 1994)	24
<i>Massachusetts v. Morash</i> , 490 U.S. 107 (1989)	6
<i>Metropolitan Life Insur. Co. v. Massachusetts</i> , 471 U.S. 724 (1985)	8
<i>Napoletano v. CIGNA Healthcare of Connecticut</i> , 238 Conn. 216 (Sup. Ct. Conn. 1996), cert. denied, 520 U.S. 1103 (1997)	14
<i>New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.</i> , 514 U.S. 645 (1995)	<i>Passim</i>
<i>Pacificare of Oklahoma, Inc. v. Burrage</i> , 59 F.3d 151 (10th Cir. 1995)	24
<i>Pilot Life Insurance Co. v. Dedeaux</i> , 481 U.S. 41 (1987)	10, 16
<i>Scheuer v. Rhodes</i> , 416 U.S. 232 (1974)	23
<i>Shaw v. Delta Airlines, Inc.</i> , 463 U.S. 85, (1983)	11
<i>Shea v. Esensten</i> , 107 F.3d 625 (8th Cir.), cert. denied, 522 U.S. 914 (1997)	20
<i>Totz v. Continental DuPage Acura</i> , 236 Ill. App. 3d 891 (2d Dist. 1992)	18

<i>UNUM Life Insurance Co. v. Ward</i> , 526 U.S. 358 (1999)	8, 10, 16
<i>Washington Physicians Serv. Ass'n v. Gregoire</i> , 147 F.3d 1039 (9th Cir. 1998), cert. denied, 119 S.Ct. 1033 (1999)	<i>Passim</i>

STATUTES AND LEGISLATIVE MATERIALS:

Del. Code Ann. tit. 18, § 6407 (1998)	14
29 C.F.R. § 2509.75-5	7
29 U.S.C. § 1002(l)	8
29 U.S.C. § 1002(l)	8
29 U.S.C. § 1022(b)	18
29 U.S.C. § 1102(a)(1)	7
29 U.S.C. § 1144(b)(2)	5
29 U.S.C. § 1144(b)(2)(A)	8
29 U.S.C. § 1191b (a)(1)	9
29 U.S.C. § 1191b (a)(2)	9
40 Pa. Const. Stat. Ann. § 991.2112 (West Supp. 1999)	14
42 U.S.C. § 300e(c)(2)	5
Alaska Stat. § 21.86.150 (i)(2) (Michie 1999)	14

Alaska Stat. § 21.86.160(I)(4)(Michie 1998)	14
Cal. Health & Safety Code § 1346.6 (West Supp. 1999)	14
Georgia Code Ann. § 33-20A-G (Supp. 1999)	14
Idaho Code § 41-3928 (1998)	14
Ill. Rev. State ch. 815, para. 505/2 (1998)	18, 19
Kansas Stat. Ann. § 40-4605 (Supp. 1998)	14
La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999) . .	14
Md. Code Ann. Ins. § 15-113(c) (1997)	14
Minn. Stat. § 72A.20, Subd. 33 (1999)	14
Mo. Rev. Stat. § 354.606(5) (Supp. 1999)	14
Mont. Code Ann. § 33-36-204(2) (1997)	14
Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998)	14
Nev. Rev. Stat. § 695G.260 (1998)	14
Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998)	14
Pa. Stat. Ann., tit. 40, § 991.2113 (Purdon 1999)	14
R.I. Gen. Laws § 23-17-17-3(B)(6) (1996)	14
Tex. Ins. Code Ann. Arts. 20A.14(1), 3.70-3C, § (7)(d) (Vernon Supp. 2000)	14

OTHER MATERIALS:

Karen A. Jordan, <i>Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption</i> , 13 Yale J. Reg. 255 (1996)	13
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INTEREST OF THE *AMICI CURIAE*

Amici curiae, the States of Illinois, California, Delaware, Florida, Iowa, Massachusetts, Mississippi, Missouri, Montana, Nevada, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee and Texas, submit this brief in support of respondent Cynthia Herdrich. The issues posed in this case have significant implications for the States' ability to regulate two areas of traditional state concern: the medical care provided to their citizens and the business practices of medical care providers. The *amici* States have a strong interest in assuring that their citizens are provided with competent medical care and that healthcare businesses market and perform their services fairly. As managed care, through the proliferation of health maintenance organizations (HMOs), has become a more common vehicle for healthcare delivery, the States have become more active in its regulation. *Amici* regulate medical care and the business of HMOs through healthcare statutes, insurance statutes, laws of general application such as consumer protection statutes, common law standards and the provision of both statutory and common law remedies.

The *amici* States also have a strong interest in the construction of ERISA. ERISA preempts State laws that "relate to" ERISA plans and are not saved from preemption by ERISA's insurance savings clause. This Court has held that state laws that "mandate employee benefit structures or their administration" "relate to" ERISA plans, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 646 (1995), and that "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans" do not "relate to" ERISA plans, *De Buono v. NYSA-ILA Medical & Clinical Serv. Fund*,

520 U.S. 806, 815 (1997). The Court's determination of the circumstances in which an HMO engages in ERISA plan administration will have significant implications for the States' ability to regulate HMOs. The States have a strong interest in preserving the appropriate balance of authority between the States and the federal government and in ensuring that ERISA preemption is not extended beyond Congressional intent. This is particularly important because the States protect consumers' interests in healthcare in numerous respects, while ERISA provides little substantive federal regulation of healthcare. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).¹

SUMMARY OF ARGUMENT

In the late 1960s and early 1970s, when ERISA was drafted and debated in Congress, the delivery of medical care was dominated by reimbursed fee-for-service medicine. Physicians rendered services they deemed appropriate for patients. After services were provided, insurers were presented with the bill and paid the reasonable cost. Healthcare services and the payment for those services were separate functions, and there was little "managed care." ERISA was not enacted with HMOs in mind.

Today, managed care is the norm. Healthcare services and payment for care are integrated into a single organization, typically the HMO. The trend toward managed care is expected to continue into the next century.

The States have traditionally regulated healthcare and the business of healthcare providers in order to protect consumers' rights to healthcare and insurance. The "starting presumption",

Travelers, 514 U.S. at 654, is that Congress, when it enacted ERISA, intended such State regulation to continue -- the Court has "unequivocally concluded" that there was no intention to undermine traditional State regulation. *De Buono*, 520 U.S. at 813. ERISA was enacted to protect consumers--"to promote the interests of employees and their beneficiaries in employee benefit plans,' ...and 'to protect contractually defined benefits'"¹--and is thus consistent with State consumer protection regulation and remedies. While Congress indicated a desire for uniform administration of benefit plans, *Travelers*, ERISA was never intended to protect healthcare businesses from State regulation and from liability for wrongful acts under State laws.

Because healthcare and managed care have become virtually synonymous, regulation of healthcare implies regulation of HMOs. In parsing federal and State interests with respect to HMOs, *amici* believe the Court should be guided by five general principles.

1. *The HMO is not the ERISA plan.* HMOs and other managed care organizations are not ERISA plans. They are healthcare businesses. They sell a product, healthcare, they arrange services, and they manage their own business. These areas are traditionally subject to State regulation, and ERISA does not change this.

2. *The fact that an HMO provides services to an ERISA plan does not relieve it from State law regulation as a healthcare business and provider of medical care.* State law regulates

¹*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989). See also 29 U.S.C. § 1001(b).

healthcare business and medical care and provides remedies to consumers for wrongful acts of healthcare providers. ERISA was enacted to augment these protections, not to eliminate them.

3. *The ERISA healthcare benefit is payment for healthcare.* ERISA plans are benefit plans created by employers. The plans are comprised of a set of rules for disbursing employee benefits. Employers may implement the plans in a variety of ways: through the purchase of insurance, through self insurance, by providing medical services themselves in-kind² and/or by contracting with HMOs for the arrangement and provision of medical services. The benefit is not any one of these vehicles, nor is it any particular services--it is payment for healthcare.

4. *Only the administration of the ERISA plan implicates ERISA duties; the administration of the HMO's business, including the arrangement and provision of healthcare, does not.* The administration of the ERISA plan is a matter of federal concern. The administration of the HMO's business is a matter of State concern.

When the HMO is selected by the employer--or, as in this case, by the employee who has been given a choice of healthcare vehicles by the employer--the HMO arranges and provides medical care. The delivery and arrangement of care and the administration of the HMO's own business are not acts

²An employee benefit plan can arrange to provide services in-kind operating its own medical facility, as was done by the plan in *De Buono*, or by contracting directly with a physician network.

of ERISA plan administration. They are subject to State regulation, not to ERISA duties.

When benefit determinations are delegated to the HMO, it wears a second hat. Under this hat, the HMO participates in the administration of the ERISA plan. When and to the extent it does so, it is subject to ERISA duties.

5. *Even when the HMO engages in plan administration, it is subject to State regulation as an insurer.* The HMO is an insurer, assuming risk of healthcare loss. 42 U.S.C. § 300e(c)(2).³ See also *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1046 (9th Cir. 1998), *cert. denied*, 119 S.Ct. 1033 (1999). Even acts of plan administration may be regulated by the States under State insurance, banking, or securities laws. 29 U.S.C. § 1144(b)(2).

These principles have a number of implications for this case. First, respondent's original Count III--that the HMO's failure to disclose its ownership structure and financial incentive arrangements violated the Illinois Consumer Fraud Act--is not preempted by ERISA. This claim was brought against the HMO as a healthcare provider and business marketing its product to consumers. It was not brought against the HMO for acts of ERISA plan administration. The district court's preemption ruling was not appealed, but it was based on an assumed equivalence between the HMO and the ERISA plan that is incorrect.

³Pursuant to the statute, the HMO may share this risk with other entities.

Second, there is no ERISA claim based on the existence of financial incentives in HMO arrangements with providers, and there is no ERISA claim based on medical treatment decisions or the arrangement of medical care, even when the HMO is also engaged in plan administration. The HMO's business and its healthcare services are not acts of plan administration. They are matters of State, not federal, concern.

Third, when the HMO wears two hats--as healthcare arranger and provider and as ERISA plan administrator--it is subject to both State and federal requirements. Respondent's original Count III stated a State claim based on the HMO's business as healthcare provider. But after the district court dismissed this claim, respondent amended her complaint, alleging in new Count III that the HMO administered the ERISA plan improperly. This is an ERISA claim. Respondent should be given an opportunity to prove that the HMO's administration of the plan was based on the HMO's financial interests and not on the standards in the plan.

ARGUMENT

I. HMOS ARE NOT ERISA PLANS--THEY ARE HEALTHCARE BUSINESSES THAT SELL PRODUCTS AND SERVICES

The nature of ERISA plan administration is central to this case. ERISA imposes fiduciary duties--and respondent states an ERISA claim--only in connection with acts of plan management or administration. This is consistent with the purpose of ERISA: to ensure that employees' expectation of benefits is not defeated by poor plan administration. *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989). ERISA

was enacted to control "the administration of benefit plans." *Travelers*, 514 U.S. at 651.

A person is an ERISA plan fiduciary "to the extent" that he or she "exercises any discretionary authority or discretionary control respecting management" of the plan or "has any discretionary authority or discretionary responsibility in the administration of such plan" (with certain exceptions not relevant here⁴). 29 U.S.C. § 1002 (21)(A). An entity contracting with an ERISA plan only acts as a fiduciary when performing administrative functions for the plan. *Varity Corp. v. Howe*, 516 U.S. 489 (1996).⁵

The nature of plan "administration" is also central to *amici*'s interest in this case. State regulation and State remedies are preempted when they "relate to" an ERISA plan (and are not saved by the insurance savings clause). The Court interprets "relate to"--a term of "frustrating difficulty", *Travelers*, 514 U.S. at 656--with reference to the "basic thrust of the preemption statute": "to permit the nationally uniform administration of employee benefit plans." *Id.*, at 657 (emphasis added). A State law that regulates HMO plan administration activities "relates to" the plan. A State law

⁴All ERISA plans are required to have a "named" fiduciary, a person, group of persons or corporation, identified in a written plan instrument. 29 U.S.C. § 1102(a)(1). A person who provides investment advice to a plan for a fee is also a fiduciary. 29 U.S.C. § 1002 (21)(A).

⁵ Rendering services to a plan is not enough to make one a fiduciary of the plan. Services providers, such as attorneys, accountants and consultants act as an ERISA fiduciary only when they are exercising discretionary authority in the administration or management of an ERISA plan. See 29 C.F.R. § 2509.75-5.

regulating HMO activities that do not constitute ERISA plan administration does not "relate to" the plan.⁶

Of course, under the "savings" clause, the States can also regulate HMOs as insurers--petitioners agree that HMOs are insurers (Pet. Br. 26-27⁷)--under State insurance laws even when such laws mandate plan administration and thus "relate to" an ERISA plan. 29 U.S.C. § 1144(b)(2)(A). See, e.g., *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999).

A. The ERISA Plan and Benefit

ERISA defines an "employee welfare benefit plan" as "any plan fund or program . . . established or maintained by an employer . . . for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits" or other benefits. 29 U.S.C. § 1002(1). A "plan, fund or program" is not defined in the statute but has been interpreted to require the existence of benefits, intended beneficiaries, a source of funding, and a procedure to apply for and collect benefits. *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

⁶See *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d at 1044. *Gregoire* is consistent with *Metropolitan Life Insur. Co. v. Massachusetts*, 471 U.S. 724 (1985); the State law in *Gregoire* was addressed to HMOs and not, as in *Metropolitan Life*, to employee plans.

⁷An HMO is, by definition, an entity that assumes 'full financial risk on a prospective basis for the provision of basic health services....' 42 U.S.C. § 300e(c)(2). *Ibid.* See also *Washington Physician Serv. Ass'n v. Gregoire*.

The plan itself is a set of rules that govern the benefit. These rules guide "determin[ation of] the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records." *Fort Halifax Packing Co, Inc. v. Coyne*, 482 U.S. 1, 9 (1987). In this case, the ERISA plan comprised the documents setting forth the terms under which State Farm, respondent's husband's employer, provided benefits to its employees and their families. The plan documents did not contain the compensation arrangements between the HMO and providers. Nor did they specify HMO financial incentives available to providers.

Under ERISA, the healthcare benefit is payment for medical care. While ERISA did not originally contain a definition of "medical care," the Health Insurance Portability and Accountability Act, a 1996 amendment to ERISA, defines "medical care" as used in ERISA to mean "amounts paid for" medical care or medical insurance, 29 U.S.C. § 1191b (a)(2). The amendment is applicable to an "employee welfare benefit plan to the extent the plan provides medical care . . . to employees or dependents . . . directly or through insurance, reimbursement, or otherwise." 29 U.S.C. § 1191b (a)(1).⁸ See also *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) ("benefits due to [the participant] under the Plan . . . are payments of the

⁸This definition is appropriate because ERISA benefits are provided in lieu of compensation. In most cases, ERISA benefits are strictly financial. Cash distributions are given to a beneficiary upon the occurrence of some contingent event, disability, retirement or death. Or the employer agrees to arrange for payment of certain services (e.g., medical care, day care and prepaid legal services) provided to plan participants. The employer may arrange for payment in any one of several different ways, including payment of the services in kind.

costs of medical services, not the medical services themselves.”).

Amici disagree with Judge Easterbrook’s statement that the “HMO system”—rather than payment for healthcare services—is the ERISA plan benefit (Pet. App. 55a, 170 F.3d at 686). This view is inconsistent with the statutory rubric. It would essentially read plan administration out of ERISA. Judge Easterbrook distinguishes “treating the Carle HMO as the benefit, rather than treating the Carle HMO as the administrator of the ERISA plan,” *ibid.*, and appears to view these categories—the plan benefit and the administration of the plan—as mutually exclusive. When the employer’s only involvement in administration is to send checks to the HMO and when all other administrative functions are delegated to the HMO, there will be, in Judge Easterbrook’s formulation, no “administration”: the HMO doesn’t administer because it is the benefit, and no one else engages in any administration. And if HMO membership, rather than payment for medical services, is the benefit, once the participant becomes a member, there will be no benefit to administer. ERISA fiduciary protections for acts of plan administration would thus be diluted or eliminated, frustrating a principal federal concern. HMOs would likely argue, moreover, that everything they do “relates to” the ERISA plan, since the HMO is the benefit, thus inhibiting State regulation of healthcare. Congress could not reasonably have intended—in enacting a statute for the protection of employee benefits—to reduce both State and federal protections for beneficiaries.

Judge Easterbrook’s statement is also inconsistent with the Court’s decisions in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) and *UNUM, supra*, which suggest that

under traditional insurance policies the benefit is payment under the policy, not the policy. There is no reason to adopt a different rule for HMOs.

B. HMO Services and Plan Administration

HMOs are not ERISA plans, they are businesses. They administer their own affairs, which comprise, broadly speaking, arrangements, often contractual in nature, with third parties to obtain materials as diverse as office supplies, real estate, and hospital and physician services, and to package these materials as a product, healthcare.⁹ The product is available to be purchased by members of the public, including ERISA plans. While the nature of the product will affect the choices available to the public, including ERISA plans, and may thus “affect a plan’s shopping decisions,” *Travelers*, 514 U.S. at 659, the arrangements by which the HMO creates and markets the product are not the plan and have no connection to the plan.

When an HMO is selected by an employer to provide healthcare coverage to its employees, the HMO becomes a service provider to the ERISA plan.¹⁰ *Washington Physicians Serv. Ass’n v. Gregoire*. This establishes a form of “connection” between the plan and the HMO. *Cf. Shaw v.*

⁹The group subscription agreement in this case identifies Carle Care HMO as “an HMO product” of the Health Alliance Medical Plans, an Illinois stock corporation. Pet App. 93-a.

¹⁰It is not uncommon for ERISA plan to engage outside service providers. Benefit consultants design plans for employers, investment consultants provide investment advice, third party administrators administer self-insured plans, and attorneys provide legal services, both to the plan and to plan participants as part of the benefit of pre-paid legal services.

Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983). But it does not mean that the HMO becomes the plan--any more than the provision of accounting services to the plan makes such services the plan. Nor does it mean that all services provided by the HMO constitute plan "administration." The States routinely regulate the business of service providers to ERISA plans.¹¹ "The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to 'relate to' an employee benefit plan--just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to 'relate to' employee benefit plans." *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d at 1045.

In determining whether an HMO's activities constitute ERISA plan administration--and thus implicate ERISA duties and establish "relat[ion] to" the plan--it is necessary to consider the precise nature of the relevant activities.

1. *HMO arrangements with providers.* One of the HMO's activities is to establish contractual arrangements with healthcare providers. These arrangements typically include compensation terms and may, as in this case, include some form of financial incentives designed to lower the cost of healthcare.

¹¹See, e.g., *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715 (9th Cir. 1997); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991).

"[I]t is critical to distinguish between the carrier's administration of the ERISA plan and 'its own administration of its business.' [Professor Jordan] suggests that the appropriate inquiry is 'whether the practice affected . . . is one of the ongoing processes and practices developed to effectuate an employer's provision of benefits . . . or whether the practice is more properly characterized as one for the administration of the business of the third-party.'" *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F.Supp. 60, 67-68 (D. Mass. 1997), quoting Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. Reg. 255, 303 (1996) (ellipses in decision).

When an HMO establishes arrangements with providers, it is administering its own business. It is not administering an ERISA plan. "[S]election and operation of provider networks is not a traditional function of ERISA plans, and surely was not a function Congress contemplated when it enacted ERISA." *Id.*, at 67. This is so because the HMO's provider arrangements are with third parties, not with the ERISA plan. They are not contained in the plan documents. They are contained in contractual agreements with third parties. "In the emerging integrated delivery systems, some entity must perform the function of deciding which [providers] will comprise the network . . . This function is clearly attenuated from functions such as claims administration and therefore should be viewed as constituting administration of its business [rather than] administration of an ERISA plan." *Id.*, at 67, quoting Jordan, 13 Yale J. Reg. at 331 (ellipsis in decision). When the HMO administers its own business by contracting with third party providers, it is not administering the ERISA plan.

States regulate HMOs' business arrangements with providers in many ways. States limit or condition financial incentive arrangements between HMOs and providers.¹² They regulate the size and exclusivity of HMO's network arrangements through any willing provider and any willing pharmacy laws.¹³ They regulate HMO services through alternative provider laws.¹⁴ They provide remedies for inadequate disclosure of arrangements between HMOs and providers.¹⁵ They regulate gag rules.¹⁶

"The claim that a law regulating the manner in which a third-party vendor offers a service or product is subject to preemption because it affects the options available to ERISA

¹²See, e.g., Alaska Stat. § 21.86.160(I)(4) (Michie 1998); Cal. Health & Safety Code § 1346.6 (West Supp. 1999); Georgia Code Ann. § 33-20A-G (Supp. 1999); Idaho Code § 41-3928 (1998); Kansas Stat. Ann. § 40-4605 (Supp. 1998); La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999); Md. Code Ann. Ins. § 15-113(c) (1997); Minn. Stat. § 72A.20, Subd. 33 (1999); Mo. Rev. Stat. § 354.606(5) (Supp. 1999); Mont. Code Ann. § 33-36-204(2) (1997); Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998); Nev. Rev. Stat. § 695G.260 (1998); Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998); 40 Pa. Const. Stat. Ann. § 991.2112 (West Supp. 1999); R.I. Gen. Laws § 23-17-17-3(B)(6) (1996); Tex. Ins. Code Ann. Arts. 20A.14(1), 3.70-3C, § (7)(d) (Vernon Supp. 2000).

¹³See, e.g., *American Drug Stores*.

¹⁴See, e.g., *Washington Physicians Serv. Ass'n v. Gregoire*.

¹⁵See, e.g., *Napoletano v. CIGNA Healthcare of Connecticut*, 238 Conn. 216 (Sup. Ct. Conn. 1996), cert. denied, 520 U.S. 1103 (1997).

¹⁶See, e.g., Alaska Stat. § 21.86.150 (i)(2) (Michie 1999); Del. Code Ann. tit. 18, § 6407 (1998); Pa. Stat. Ann., tit. 40, § 991.2113 (Purdon 1999).

plans relies on logic that is not easily bounded; this reasoning could easily preclude state laws designed to control the quality of health care. The Supreme Court in *Travelers* emphasized that Congress did not intend ERISA to supersede such legislation." *American Drug Stores*, 973 F. Supp. at 69. The arranging of medical services is part of the healthcare business of the HMO, and it is not ERISA plan administration.

2. *Healthcare services.* One of the services that an ERISA plan may purchase from the HMO is medical care. The provision of medical care is not an ERISA plan administration function. "[W]hen the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or through contracts with hospitals, doctors or nurses. In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care." *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3rd Cir. 1999).

The States routinely regulate the quality of healthcare provided to their citizens, including members of ERISA plans, by setting quality standards and providing remedies for inadequate quality of care. This is an important State function that the Court stated it "will never assume lightly that Congress has derogated." *Travelers*, 514 U.S. at 654. The provision of healthcare services to an ERISA plan is not an act of plan administration, and it does not relieve the HMO from its State law responsibilities as a provider of healthcare. *Id.*, at 660.

3. *Claims processing or benefit determinations.* Of the functions constituting plan administration, the determination of benefits--whether particular services are covered under the ERISA plan--is one of the most important to plan members.

Fort Halifax Packing, 482 U.S. at 9. This function may be performed by the employer or may be delegated to a third party, such as a company that specializes in plan administration. The function may also be delegated to the HMO.¹⁷

When HMOs process claims and determine benefits under an ERISA plan, they "play two roles, not just one." *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995). Insofar as the HMO provides or arranges medical services for an ERISA plan, it is not engaging in plan administration. But the HMO does engage in plan administration--and is subject to ERISA fiduciary duties--when and to the extent it makes a discretionary determination of covered benefits.¹⁸

II. THE ORIGINAL COUNT III IS NOT PREEMPTED BY ERISA

Count III of the original complaint alleged that petitioners violated the Illinois Consumer Fraud Act by failing to disclose material facts regarding the ownership of the HMO and the

¹⁷It does not matter who makes the benefit determinations--the employer, a third party administrator, an insurer, or an HMO. Any entity processing claims is performing a plan administration function. *See, e.g., Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1352 (11th Cir. 1998); *Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1035 (6th Cir.), *cert. denied*, 510 U.S. 819 (1993).

¹⁸*See, e.g., Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996).

The States may regulate claims processing within their power to regulate the business of insurance. *See, e.g., Pilot Life, supra; UNUM.*

compensation of HMO physicians (Pet App 76a). The district court dismissed the claim, ruling that it was preempted because (1) it alleged that "defendants failed to disclose relevant information regarding operation of the Plan" (Pet App. 77a), (2) ERISA comprehensively regulates ERISA plan disclosure requirements, and (3) the claim sought to impose additional disclosure requirements on the plan administrator (Pet App. 77a).

This ruling was not appealed and is not before the Court. But it was incorrect, and it demonstrates the danger of equating the HMO with the plan and ignoring the functional distinctions between the HMO's administration of its business and the HMO's administration of the ERISA plan.¹⁹

The HMO is not the ERISA plan. It performs services for the plan. In this case, one of the services performed by the HMO was plan administration, the determination of benefits. But the HMO was not acting as ERISA plan administrator when it set up its business. It was not acting as plan administrator when it entered into compensation arrangements with third parties. Nor was it acting as a plan administrator when it failed to disclose these arrangements to consumers of its medical services. The disclosure requirements of the Illinois Consumer Fraud Act are imposed on HMOs as businesses that sell healthcare products to consumers in Illinois. They are not imposed on ERISA plans.

ERISA does require disclosure of certain plan information, including the identity of plan trustees, eligibility requirements

¹⁹*Amici* urge the Court to make clear that it does not endorse dismissal of the State claim.

for participation and benefits, the source of financing, the organization through which benefits are provided, claims procedures, and appeal rights. 29 U.S.C. § 1022(b). But respondent's State claim was predicated on the HMO's failure to disclose material facts about *its own business*, not about the plan. ERISA is not concerned with the business arrangements between service providers and third parties.

The Illinois Consumer Fraud Act permits consumers, including ERISA plan participants, to make informed benefit choices. The Act prohibits unfair or deceptive acts or practices in any trade or commerce, including the concealment, suppression or omission of any material fact with the intent to induce reliance by others. Ill. Rev. State ch. 815, para. 505/2 (1998); *Totz v. Continental DuPage Acura*, 236 Ill. App. 3d 891, 902 (2d Dist. 1992). It provides a remedy for a business' failure to disclose material information under the terms of the Act. ERISA plan participants are entitled to such routine protections of State law with respect to consumer transactions so long as those laws do not "relate to" an ERISA plan. *Travelers*, 514 U.S. at 655-56.

In determining whether a State law "relates to" an ERISA plan, the "starting presumption" is against "relat[ion] to" the plan. *Travelers*, 514 U.S. at 654. "[W]e have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.*, at 655 (citations omitted). Consumer protection is an area of traditional state concern, *Cipollone v. Liggett Group*, 505 U.S. 504, 530 (1992), as is the "state's historic powers to regulate matters of health and safety" and the "two areas of traditional state governance--the health care and insurance industries." *American Drug*

Stores, 973 F.Supp. at 65. A party seeking to eliminate State regulation or escape liability under State law "bear[s] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 520 U.S. at 814.

Armed with the presumption, the Court looks "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656. The principal objective, the *Travelers* Court found, is uniform plan administration. The Court stated that this objective is not implicated where State law does not "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one." *Id.*, at 660. Nor is it implicated where State law "simply bears on the costs of benefits" or where it "can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get" *Ibid.*

The Illinois Consumer Fraud Act does not "mandate employee benefit structures or their administration." *Id.*, at 658. It does not preclude uniform administrative practice or a uniform interstate package. It does not regulate the terms of a plan or the calculation of benefits under a plan. It only requires a provider of services to disclose material information about its business. Ill. Rev. State ch. 815, para. 505/2 (1998).

That there is no "relat[ion] to" the plan is clear from consideration of a more draconian measure. Assume the State outlawed HMO financial incentives entirely, prohibiting HMOs from offering such incentives to providers. The only conceivable affect on an ERISA plan would be an increase in costs through the elimination of countervailing incentives to

lower cost. Benefits are unaffected. Administrative practices are unaffected. Plan terms are unaffected. But the *Travelers* Court has already said that a State law with "indirect economic influence [that] does not bind plan administrators to any particular choice" does not "relate to" an ERISA plan. A law that only "bears on the costs of benefits" does not "relate to" the plan. A law that only influences a plan's "shopping decisions" does not "relate to" the plan. *Id.*, at 659-660. Elimination of incentives in HMO contracts with third party providers might make an HMO's services more expensive, but it would have no other affect on the plan, and a law prohibiting such incentives would not "relate to" the plan. If a State law that prohibits incentives entirely does not "relate to" an ERISA plan, a State law that requires disclosure of such arrangements surely cannot.

Two circuit court decisions have held that State law claims against an HMO for failure to disclose financial incentive arrangements were preempted. *Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997); *Anderson v. Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994). (*Shea* also ruled that HMOs have a fiduciary duty under ERISA to disclose financial incentives.) Both decisions are incorrect, and for the same reason: the courts equated the HMO with the plan or with plan administration. In *Shea*, the court found that the claim addressed "plan disclosures" and that "administrators would be forced to tailor their plan disclosures" to State requirements. 107 F.3d at 627. But the plan did not contain the incentive arrangements--these were contained in the HMO's arrangements with providers. And the "plan" was not compelled to disclose anything; only the HMO was required to

disclose information about its business.²⁰ The *Anderson* court found, similarly, that the plaintiff "wants employers" to change "the descriptions of the welfare benefit plan... [in] literature distributed as part of a plan's administration," 24 F.3d at 891. Again, HMO financial incentives are not part of the plan. They are part of the HMO's business arrangements with third parties and are not contained in plan documents. The employer in *Anderson* didn't have to do anything--only the HMO as healthcare business was required to disclose material facts about its business.

HMOs provide services to ERISA plans. But this does not relieve them of their obligation to ensure that handbooks, brochures and other marketing materials offered to the public, including plan participants, contain disclosures about HMO business practices required by State law. Because HMO businesses differ from state to state (and even within states), disclosures regarding HMO business practices will differ from state to state (and even within states).²¹ This does not impose

²⁰The court also stated that "claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision." 107 F.3d at 627. Even were ERISA's preemption "broad", *cf. Travelers; California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997), *De Buono*, this is much too broad. Not all claims against a plan administrator are preempted--only claims based on acts of plan administration.

²¹As a result of State insurance and business regulation, both the terms and benefits offered by HMOs and the medical structures of HMOs will vary from State to State, and thus (1) disclosure by HMOs will never be uniform in all States and (2) a rule requiring disclosure of HMO financial incentives will not disturb any existing uniformity in HMO disclosure practices.

burdens on the ERISA plan, any more than HMO compliance with State laws regulating landscaping or accounting burden the plan.

The Illinois law is consistent with ERISA's goal of protecting plan members. It does not interfere in any way with any ERISA function. It is not preempted.

State laws regulating the business activities of entities that sell products to ERISA plans do not "relate to" plans. "[L]aws that regulate only the insurer, or the ways it sells insurance do not relate to benefit plans in the first instance." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 741.²² The application of the Illinois Consumer Fraud Act to the HMO does not "relate to" the ERISA plan, and the district court erred in dismissing the original Count III and not remanding the case to State court.

²² In *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, the court distinguished between an HMO acting as ERISA plan administrator and an HMO acting as a healthcare business engaged in a contractual relationship with providers. 187 F.3d 1045 (9th Cir. 1999). The court held that the providers' claim based on a term in the provider agreement was not preempted. In *In re U.S. Healthcare*, the court ruled that claims based on "the HMO's role in 'arranging for medical treatment' rather than its role in determining what benefits are appropriate" were not preempted, 193 F.3d at 163. Where allegations "do not raise the failure of [the HMO] to pay for a benefit or process a claim for benefits as the basis for the injury suffered" *ibid.*, the claim does not relate to the plan. In *Coyne & Delany Co. v. Selman*, the court distinguished two roles played by an employee benefit consultant who designed an ERISA plan and then became plan administrator, ruling that a professional malpractice claim against the consultant for negligence in the design of the plan was not preempted. 98 F.3d 1457 (4th Cir. 1996).

III. RESPONDENT STATES AN ERISA CLAIM WHEN SHE PLEADS THAT HMO BENEFIT DETERMINATIONS IN ADMINISTRATION OF THE PLAN WERE BASED ON THE HMO'S OWN FINANCIAL INTERESTS

"A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts that would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). It is axiomatic that the complaint must be read in the light most favorable to the non-moving party. *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974).

At the district court's direction, respondent re-pled Count III under ERISA. The new claim no longer alleged failure to disclose material facts. Instead, it alleged that the HMO breached its fiduciary duty in two ways:

--i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

- (1) minimize the use of diagnostic tests;
- (2) minimize the use of facilities not owned by CARLE; and
- (3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians [and]

--ii. by administering disputed and non-routine health insurance claims and determining:

- (1) which claims are covered under the Plan and to what extent;
- (2) what the applicable standard of care is;
- (3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency,

all in order to augment their incomes. *Herdreich v. Pegram*, 154 F.3d 362, 373 (7th Cir. 1998).

1. *The claim based on medical services.* The first claim refers to decisions by physicians to perform (or not perform) certain tests, to use (or not use) certain facilities, and to make (or not make) certain referrals to other physicians. Claims based on the provision or arrangement of medical services, including claims based on physicians' decisions as to the appropriate treatment, place of treatment and provider of treatment, are not ERISA claims. Physicians do not engage in plan administration when they perform medical services or make medical decisions. Any claim against the HMO based on medical services of healthcare providers must be brought under State law.²³

2. *The claim based on benefit determinations.* While the second claim is not clearly drafted, it appears to include both allegations of improper medical decisions and improper benefit determinations. Medical decisions are subject to State regulation, whether such decisions are made by the doctor or the HMO. If, for instance, the HMO, using medical judgment, decided that a treatment was or was not medically necessary in order to increase its income, this would implicate State (not

²³Several courts have entertained vicarious liability claims against HMOs for wrongful acts of physicians. See, e.g., *In re U.S. Healthcare; Dukes v. U.S. Healthcare, Inc.*; *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Lupo v. Human Affairs Intern., Inc.*, 28 F.3d 269, 272 (2d Cir. 1994).

federal) regulation. Without a factual record, it is not possible to ascertain whether the HMO conduct alleged in claim ii involved medical decisions or benefit determinations or both.

While the ultimate disposition of this case will depend on facts developed in discovery--and the facts may ultimately show only improper medical judgment, subject to State regulation, or discretionary determinations under the ERISA plan, subject to ERISA fiduciary duties, or both--the complaint alleges that the HMO "administer[ed] disputed and non-routine health insurance claims and determine[d] which claims are covered under the plan and to what extent" Petitioners appear to acknowledge that they were subject to ERISA fiduciary duties when administering claims; in their brief they distinguish HMO business decisions from "coverage and eligibility decisions" and concede that they are fiduciaries when making such coverage and eligibility decisions (Pet. Br. 28).

Fiduciaries breach ERISA's duty of loyalty when they place their own financial interests ahead of the interests of plan participants in making administrative decisions. See *Donovan v. Bierwirth*, 680 F.2d 263 (2d Cir.), cert. denied, 459 U.S. 1069 (1982). A particularly black and white instance of such a breach would occur when an administrator receives a cash payment for denying a claim (see U.S. Br. 34). When an administrator's fiduciary decision is alleged to be based on a personal financial interest or a corporate financial interest, rather than an evenhanded approach based on plan criteria and the employees' interest in receiving plan benefits, there is a claim for breach of an ERISA fiduciary duty.

HMOs act both as healthcare businesses and medical care providers--subject to State law--and as ERISA plan

administrators--subject to federal law. For this reason, HMOs should be responsible for their wrongful business and medical conduct under State law and for improper ERISA plan administration under federal law--and in some cases, where both business and/or medical conduct and plan administration are improper, under both laws. Put another way, (1) HMOs should not escape responsibility for their actions as ERISA plan administrators simply because they are also healthcare businesses and perform healthcare services and (2) the fact that HMOs perform some acts of plan administration does not relieve them of their State law responsibilities as healthcare businesses and providers of medical services. Because the precise nature of the HMO's actions alleged in claim ii is unclear, *amici* respectfully suggest that the case should be sent back to the district court so that the HMO's conduct may be evaluated based on a full factual record.

CONCLUSION

The judgment of the court of appeals should be affirmed to allow a full development of the record.

Respectfully submitted,

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In The
Supreme Court of the United States

**CARLE CLINIC ASSOCIATION and
HEALTH ALLIANCE MEDICAL PLANS, INC.,**

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

**On Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit**

**BRIEF AMICUS CURIAE OF THE
AMERICAN COLLEGE OF LEGAL MEDICINE,
THOMAS W. SELF, M.D. AND LINDA P. SELF, R.N.
IN SUPPORT OF RESPONDENT**

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36 pp

TABLE OF CONTENTS

STATEMENT OF INTEREST	1
SUMMARY OF THE ARGUMENT	3
ARGUMENT	5
I. ARE PETITIONERS SUFFICIENTLY ALLEGED TO BE ERISA FIDUCIARIES	6
A. Who are the Petitioners?	6
B. Which Parties did the Seventh Circuit Find to be ERISA Fiduciaries?	10
C. What is an ERISA Fiduciary?	12
D. Are CARLE and HAMP Sufficiently Alleged to be ERISA Fiduciaries?	14
E. Conclusion	16
II. THE SUBJECT COST-CONTAINMENT MECHANISM DIVIDES PHYSICIANS' LOYALTY TO PATIENTS	16
CONCLUSION	23
APPENDIX	
A. Petitioners' Letter of Consent to File <i>Amicus</i> Brief	

- B. Petitioner Health Alliance Medical Plans, Inc.'s Letter of Consent to File *Amicus* Brief
- C. Respondent's Letter of Consent to File *Amicus* Brief

TABLE OF AUTHORITIES

Cases

<i>Herdrich v. Pegram</i> , 154 F.3d 362 (7 th Cir. 1998)	7,9-11,18
<i>Lujan v. Defenders of Wildlife</i> , 504 U.S. 555, 112 S.Ct. 2130 (1992)	10-11
<i>Varity Corp. v. Howe</i> , 516 U.S. 489, 116 S.Ct. 1065 (1996)	22

Statutes and Rules

Employee Retirement Income Security Act of 1974 ("ERISA") 29 U.S.C. §1001 <i>et seq.</i> ...	2,3,6
29 U.S.C. §1002(21)(A) (ERISA)	12
29 U.S.C. §1104(a)(1) (ERISA)	22
Rule 12(b)(6) of the Federal Rules of Civil Procedure	<i>passim</i>
Rule 37 of the Rules of the United States Supreme Court	1

Other Authorities

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STATEMENT OF INTEREST

The American College of Legal Medicine ("ACLM"), and Thomas W. Self, M.D. and Linda P. Self, R.N. (together, "the Selfs"), respectfully submit this brief as *amici curiae* pursuant to Rule 37 of the Rules of the United States Supreme Court. The ACLM and the Selfs do not *per se* support either Petitioners or Respondents in this case, but, rather, write to more clearly define certain issues, and to offer their considerable collective experience with financial incentives provided by managed care organizations ("MCOs"), and the impact of certain incentives on healthcare delivery. These amici file their brief along with Respondent because their position is arguably and indirectly more supportive of Respondent's cause. The ACLM and the Selfs have received the consent of all parties to submit this brief pursuant to the applicable rules of this Court. See Appendix A.

Founded in 1960, the ACLM is an organization of professionals concerned with issues arising at the convergence of law and medicine. The ACLM's membership consists of about 1500 professionals, including physicians in most every specialty, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM Fellows, as well as a significant portion of the college's membership, hold professional degrees in both law and medicine.

Thomas W. Self, M.D. is a Yale and UCLA trained pediatric gastroenterologist, who has practiced medicine in San Diego, California since 1972. Dr. Self recently attained national recognition for a unique lawsuit he filed against the physician group in which he formerly practiced. In that case, Dr. Self alleged that his employment with that group had been terminated because he refused to succumb to "bottom line" financial pressures imposed by the MCOs with which his group was affiliated. Specifically, Dr. Self alleged that he was fired

because, according to these MCOs (and his physician group), he devoted too much time to, and ordered too many tests for, his patients. After a contentious three month trial and eight days of jury deliberation, the jury awarded Dr. Self compensatory damages in the amount of \$1.75 million; before the jury was to determine punitive damages, the parties settled the case for \$2.5 million. This landmark litigation was the subject of testimony by Dr. Self in 1998 at a bicameral congressional hearing on proposed patients' rights legislation, and also has been profiled in various television and print media.

Linda P. Self, R.N., is a registered nurse and medical administrator, with many years experience both in providing medical care and treatment, and processing patient claims to MCOs. Ms. Self is particularly familiar with MCO cost-containment mechanisms and has witnessed first-hand their adverse impact on healthcare delivery.

The ACLM's and the Self's interest in the instant lawsuit initially derived solely from their collective interest in maintaining the sanctity of the physician-patient relationship, and in eliminating any barriers that harm this relationship, including financial incentives that infringe upon physicians' ability to deliver quality healthcare. These *amici* are particularly concerned that certain cost-containment mechanisms imposed by MCOs compel even the most ethical physicians to consider foregoing potentially appropriate treatment to maintain their affiliations with, and satisfy, MCOs. The ACLM and the Selfs write, in part, to offer their experience as to how the cost-containment mechanism at issue here can, indeed, adversely affect the delivery of quality healthcare.

Review of the briefs filed by Petitioners and some of their supportive *amici*, however, have generated an additional interest of the ACLM and the Selfs. It is posited in these briefs that the court below improperly held that MCOs and physicians are fiduciaries under the Employee Retirement Income Security

Act of 1974 ("ERISA"). The ACLM and the Selfs have a profound interest in ensuring that physicians' clinical obligations to their patients are not confused with, or otherwise hampered by, any purported obligations under ERISA. In this regard, the ACLM and the Selfs write to argue that physicians are not *per se* ERISA fiduciaries, and that the court below did not find, and could not have found, otherwise.

SUMMARY OF THE ARGUMENT

In their brief, Petitioners contend that the two fundamental issues on appeal are (i) whether Petitioners are fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA"), and (ii) if Petitioners are ERISA fiduciaries, whether they breached their fiduciary duty under ERISA by paying financial incentives to physicians for minimizing patient care and treatment. Petitioners and their supporting *amici* argue, in essence, that the Seventh Circuit Court of Appeals answered both questions in the affirmative, and that that decision is improper because neither managed care organizations ("MCOs") nor physicians are ERISA fiduciaries.

The ACLM and the Selfs respectfully submit that Petitioners misstate the Seventh Circuit's ruling and the issues on appeal, and that Petitioners and their supportive *amici* unnecessarily complicate the issues in this case. While the ACLM and the Selfs concur that neither MCOs, nor, in particular, physicians, are *per se* ERISA fiduciaries, these *amici* are compelled to offer some additional insight as to the actual issues on appeal. Specifically, the ACLM and the Selfs do not believe that the court below did find, or even could have found, either physicians or MCOs to be *per se* ERISA fiduciaries – a fact illuminated by clarification on several points critical to this appeal.

First, there is confusion as to the actual identity of the Petitioners themselves. The only Petitioners in this appeal are the Carle Clinic Association ("CARLE") and Health Alliance Medical Plans, Inc. ("HAMP"), neither of which is an MCO or a physician. The ACLM and the Selfs urge this Court to reaffirm this fact.

Second, these *amici* also urge this Court to make certain the ultimate holding of the court below. The briefs of Petitioners and some of their supportive *amici* appear to read the decision from which this appeal is taken as finding MCOs and physicians to be ERISA fiduciaries. The Seventh Circuit did not, should not and could not have rendered such a ruling, because (a) no MCO, and certainly no physician, is a party to this appeal or the appeal to the court below, and (b) such a holding confounds the applicable statutory definition of "fiduciary."

Third, the ACLM and the Selfs note that the fiduciary duties imposed under ERISA are delegable in nature. By statutory definition, ERISA fiduciary status extends to *any* entity or person who has or exercises any discretionary authority, control or responsibility in the management or administration of an employee benefit plan. Whether any entity or person is an ERISA fiduciary, therefore, depends entirely upon their role in the management and administration of a plan, rather than upon their corporate structure, business purpose or personal occupation. The question in this appeal, then, pertains not to MCOs and certainly not to physicians generally, but rather pertains specifically to CARLE and HAMP, and their role in the management and administration of the subject health plan.

Finally, the ACLM and the Selfs note that the district court dismissed Respondent's ERISA claim pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. The actual question on appeal, therefore, is not whether CARLE and

HAMP are, in fact, ERISA fiduciaries, but rather whether Respondent *sufficiently alleged* that these entities are ERISA fiduciaries, *i.e.*, that they had or exercised any discretionary authority, control or responsibility in the management or administration of the subject health plan. If Respondent did, the Seventh Circuit properly reversed the district court's ruling in this regard, and Respondent should be afforded the opportunity to prove her allegations. The ACLM and the Selfs respectfully submit that Respondent satisfied this pleading standard, and, therefore, the Seventh Circuit's ultimate decision on this fiduciary issue should be affirmed.

With respect to the second issue on appeal, the membership of the ACLM and the Selfs offer this court their considerable experience in today's managed care environment, to express just how incongruous the financial incentives at issue in this appeal are with physicians' duty of loyalty to their patients, physicians' mission to provide quality healthcare, and their allegiance to adhere to the precepts of the Hippocratic Oath, *i.e.*, "[n]ever do no harm to anyone." Cost-containment mechanisms are not *per se* detrimental to this cause, and, arguably, are inevitable in a private healthcare system. However, mechanisms which provide cash incentives to physicians that have the affect of minimizing care and treatment most assuredly do not work to the benefit or interest of patients. And, importantly, this particular mechanism does not arise out of balanced contractual negotiations between managed care entities and their affiliated physicians, but, instead, is imposed upon physicians. The ACLM and the Selfs take no position on whether the imposition of the cost-containment mechanism at issue on appeal falls within the rubric of ERISA and the fiduciary responsibilities imposed thereunder. The ACLM and the Selfs strongly believe, though, that the subject financial incentives are contrary to patients' best interests.

ARGUMENT

The ACLM and the Selfs submit that the issues on appeal have been confused and unnecessarily complicated, if not misstated, in the briefs of Petitioners and their supportive *amici*. Petitioners represent that this appeal presents the following two fundamental questions: (i) whether Petitioners are fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA"), and (ii) if Petitioners are ERISA fiduciaries, whether they breached their fiduciary duty under ERISA by allegedly imposing a cost-containment mechanism which provides financial incentives to physicians for minimizing patient care and treatment. However, this case reaches this Court on the issue of whether the Seventh Circuit Court of Appeals properly reversed the district court's dismissal of this lawsuit pursuant to Fed.R.Civ.P. 12(b)(6). The issue, then, is not whether Petitioners are ERISA fiduciaries or whether they breached their fiduciary duty by imposing the cost-containment mechanisms at issue in this case, but, rather, whether Respondent Cynthia Herdrich ("Herdrich") *sufficiently alleged* these conclusions as facts in her Amended Count III.

I. ARE PETITIONERS SUFFICIENTLY ALLEGED TO BE ERISA FIDUCIARIES?

The ACLM and the Selfs respectfully submit that an accurate review of the facts on several issues – issues clouded by the briefs of Petitioners and some of their supportive *amici* – demonstrates that Herdrich, in fact, *did* sufficiently allege Petitioners to be ERISA fiduciaries.

A. Who are the Petitioners?

Petitioners and several of their supportive *amici* ask this Court to overturn the Seventh Circuit's decision based on the contention that the appellate court improperly held that HMOs and physicians are *per se* ERISA fiduciaries. The ACLM and

the Selfs would share this concern if they similarly interpreted the Seventh Circuit's ruling; but they do not. A first issue critical to understanding the decision below, and on which there appears to be real confusion, is the actual identity of the Petitioners. The necessary identity of the Petitioners is demonstrated through the procedural history of this case and the pleadings below.

The procedural history of this case is well-detailed in Petitioners' filings in this Court and in the Seventh Circuit's August 18, 1998 opinion. *See* Petition for Writ of *Certiorari* (at pp. 4-8); Brief of Petitioners (at pp. 7-15); *Herdrich v. Pegram*, 154 F.3d 362, 365-367 (7th Cir. 1998). Respondent Cynthia Herdrich ("Herdrich") originally filed in state court a two-count complaint alleging professional negligence against Lori Pegram, M.D. and against CARLE. *Id.* Herdrich then amended her state court complaint to add two new counts (Counts III and IV) alleging state law fraud against both CARLE and a new defendant, HAMP (HAMP being a corporation that (a) operates an HMO known as CarleCare HMO, and (b) is wholly-owned by CARLE). *Id.* CARLE and HAMP removed the case to federal court, based on their contention that the newly added Counts III and IV against CARLE and HAMP were preempted by ERISA, an argument with which the federal district court agreed. *Id.* Thereafter, the district court entered judgement for CARLE and HAMP on Count IV, and it granted Herdrich leave to amend Count III to proceed under ERISA. *Id.*

Herdrich then filed her Amended Count III, alleging that defendants to that count breached their fiduciary duty to plan participants and beneficiaries by implementing a cost-containment mechanism that provided physicians with financial rewards for minimizing certain medical treatment and for minimizing referrals to physicians and facilities outside the HMO network. *Id.*

The identity of the Amended Count III defendants is plainly set forth in that pleading:

NOW COMES plaintiff, CYNTHIA HERDRICH, by her attorneys, Hayes, Hammer, Miles Cox and Ginzkey complaining of CARLE CLINIC ASSOCIATION, P.C. (hereinafter "CARLE"), HEALTH ALLIANCE MEDICAL ASSOCIATION, P.C. (hereinafter "HAMP") and CARLE HEALTH INSURANCE MANAGEMENT CO., INC. (hereinafter "CHIMCO") as follows:

THE PARTIES

1. CARLE is an Illinois corporation comprised of owner/physicians and is doing business in the central district of Illinois.
2. HAMP is a for-profit Illinois Domestic Stock Insurance Company doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.
3. CHIMCO is a for-profit Illinois corporation doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.

JURISDICTION

4. This court has jurisdiction....

Amended Count III at pp. 1-2.¹

The Count III defendants -- CARLE, HAMP and CHIMCO -- moved to dismiss Amended Count III pursuant to Fed.R.Civ.P. 12(b)(6), which motion the district court granted. *See* Petition for Writ of *Certiorari* (at P. 6); Brief of Petitioners (at p. 10); *Herdrich*, 154 F.3d 362, 367. Herdrich appealed that dismissal ruling to the Seventh Circuit, which reversed the district court, and now "Petitioners" appeal that decision to this Court.

So, who are Petitioners in this appeal? The ACLM and the Selfs respectfully submit that Petitioners themselves are unclear on this point. Petitioners, in their brief, identify themselves as those parties "listed in the caption of the case." Brief of Petitioners at p. ii. However, the caption on the cover of their brief identifies Petitioners as Lori Pegram, M.D., CARLE and HAMP, and Petitioners continue on in the body of their brief to identify each of these three as "Petitioners." *See, e.g.*, Brief of Petitioners at p. 6 ("through petitioner, [CARLE], doing business as"), at p. 8 ("received from petitioner Dr. Lori Pegram"). Adding confusion, Petitioners also contend that CHIMCO -- an entity not referenced in their caption -- is also a petitioner. Brief of Petitioners at p. 7; *but see Amicus Brief of the United States* at p. 4, fn. 2 ("CHIMCO is not a petitioner in this Court.")

These *amici* respectfully disagree with Petitioners' characterization of their own identity. First of all, it is clear from the procedural history of this case that the only matter appealed to the Seventh Circuit and, thereafter, to this Court, are rulings on Respondent's Amended Count III; Petitioners

¹ A majority of the text of Amended Count III is set forth both in Petitioner's brief (at pp. 9-10, fn. 6) as well as in the Seventh Circuit's opinion (154 F.3d at 366, fn. 3), but neither includes this introductory text that identifies the defendants to that count.

admit that. See Petition for Writ of *Certiorari* (at p. 5) and Brief of Petitioners (at p. 8) ("On September 1, 1995, Herdrich filed her amended Count III. That count is the subject of the decision at issue here."); see also *Herdrich*, 154 F.3d at 367 ("On appeal [to the Seventh Circuit], Herdrich contends that the district court erred in dismissing the amended count III").

Furthermore, there can be no dispute that the only defendants to Herdrich's Amended Count III are CARLE, HAMP and CHIMCO. As the only defendants in this count, CARLE, HAMP and CHIMCO are the only parties with standing to be respondents to Herdrich's appeal to the Seventh Circuit, and, in turn, the only parties potentially to have standing to be Petitioners from the Seventh Circuit's decision. See, e.g., *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 2136 (1992) (setting forth standing requirements). This fact is further buttressed by the Seventh Circuit's opinion in which that court specifically named CARLE, HAMP and CHIMCO as defendants-appellees in that appeal. *Herdrich*, 154 F.3d 362, 365.

For the foregoing reasons, it is clear that Petitioners to this Court may be comprised of *only* CARLE, HAMP and CHIMCO. And while Dr. Pegram was a defendant to Herdrich's Counts I and II, it is undisputed that those counts sounded in professional negligence, and, moreover, that Dr. Pegram was *never* a party to Amended Count III. Simply stated, Lori Pegram, M.D., is not, and could not be, a Petitioner, and these *amici* respectfully ask this Court to make this fact clear.

B. Which Parties did the Seventh Circuit Find to be ERISA Fiduciaries?

Although the Seventh Circuit's opinion speaks for itself, there appears to be substantial confusion as to precisely *who* the

court found to be an ERISA fiduciary. Petitioners and several of their supportive *amici* write that the appellate court held Lori Pegram, M.D. to be an ERISA fiduciary. However, as shown above, the Seventh Circuit should not, and could not, have reached such a conclusion because Dr. Pegram was not a party to the Seventh Circuit appeal. It is well-settled that the rights and liabilities of a person or entity cannot be adjudicated in a proceeding to which that person or entity is not a party. See, e.g., *Lujan v. Defenders of Wildlife*, *supra*.

Furthermore, the ACLM and the Selfs submit that the Seventh Circuit's opinion clarifies that that court did *not* find Dr. Pegram to be an ERISA fiduciary:

[Taking Herdrich's allegations to be true] ...
[w]e can reasonably infer that Carle and HAMP
were plan fiduciaries due to their discretionary
authority in deciding disputed claims.

* * * * *

Contrary to the defendants' assertion, and the
magistrate's conclusion, CARLE and HAMP
are, in fact, fiduciaries.

Herdrich, 154 F.3d at 369, 370, 371. At no point in that opinion does the Seventh Circuit state expressly or impliedly that Dr. Pegram, or any other physician, is an ERISA fiduciary.

Furthermore, no where in the Seventh Circuit's decision does that court discuss or ever find CHIMCO – the only other possible Petitioner in this appeal – to be an ERISA fiduciary. Accordingly, since CHIMCO is not subject to an adverse ruling, it has no basis on which to petition this Court, and, therefore, CHIMCO is not and cannot be a Petitioner in this appeal. See, e.g., *Lujan v. Defenders of Wildlife*, *supra*.; see

also *Amicus* Brief of the United States at p. 4, fn. 2 ("CHIMCO is not a petitioner in this Court.").

In sum, the only parties to comprise the Petitioners in this appeal are CARLE and HAMP, as these are the only entities which the Seventh Circuit found potentially liable under Herdrich's ERISA claim.

It is, moreover, the case that neither CARLE nor HAMP is an MCO. The text of Amended Count III, the Petitioners' own brief and the Seventh Circuit's opinion make clear that the MCO at issue in the underlying claim is an entity entitled "CarleCare HMO" – which is not a party to Amended Count III, not a petitioner to the Seventh Circuit and not a petitioner to this Court. Accordingly, not only did the Seventh Circuit not find Dr. Pegram or any other physician to be an ERISA fiduciary, it also did not find any MCO to be an ERISA fiduciary. Granted, HAMP is alleged to own and operate CarleCare HMO. But that fact does not transform HAMP, itself, into an HMO. As shown below, this is a critical distinction.

C. What is an ERISA Fiduciary?

It is clear from the definition of "fiduciary" as well as from the duties ascribed to fiduciaries as set forth in ERISA, that such duties are delegable in nature. ERISA's application is certainly limited to employee health plans, but the definition of fiduciary is not so limited. An ERISA fiduciary is *any* entity or person who has or exercises any discretionary authority, control or responsibility in the management or administration of an employee benefit plan.² 29 U.S.C. §1002(21)(A). Whether any entity or person is an ERISA fiduciary, therefore, depends

² Because many of the briefs filed to date in this appeal fully set forth the language of ERISA defining "fiduciary" and describing an ERISA fiduciary's obligations, these *amici* will not repeat those lengthy statutory provisions.

entirely upon their role in the management and administration of an ERISA plan.

From that statutory definition, fiduciary status may not be *per se* imposed upon employers or MCOs or physicians. The description of an entity's business structure or purpose, like a description of a person's occupation or profession, has no bearing whatsoever on whether an entity or a person is an ERISA fiduciary. As Petitioners and their supportive *amici* accurately aver, the business functions of an MCO, and, assuredly, the clinical duties of physicians, are indisputably separate and distinct from the administration and management of an employee health plan. Consider, for example, that some employers administrate and manage their own health plans. In that circumstance, the employer takes on the role of ERISA fiduciary. That the employer retains an MCO, which, in turn, provides medical benefits through physicians, does not *per se* transfer the plan's administrative or management functions to the MCO or to the physicians.

On the other hand, nothing in ERISA proscribes the delegation of the administration and management of the plan by the employer to some other entity or person. Surely, an MCO or a physician could administer or manage an ERISA plan, just as a plumber, a teacher or an electrician could take on those tasks. But, clearly, the role of plan administrator and manager is separate and distinct from the business functions of an MCO, the clinical functions of a physician, and the occupational functions of a plumber, a teacher and an electrician. It, therefore, would be error to conclude that any entity or person – whether MCO, physician, plumber, teacher, electrician or otherwise – cannot as a matter of law be an ERISA fiduciary, at least without factual information as to what, if any, role that entity or person played in the administration and management of an ERISA plan.

Even assuming *arguendo* that either of the Petitioners is an MCO, Petitioners ask this Court to take an extreme and unwarranted position that, because they are MCOs, they should never be adjudged an ERISA fiduciary. Petitioners are right to argue that the business functions of an MCO are separate and distinct from the functions of administering an ERISA plan. But an MCO, in addition to its business functions, could certainly *also* serve as a plan administrator.

In sum, whether any entity or person is an ERISA fiduciary depends upon their particular role in the management and administration of an ERISA plan, an inquiry which is primarily, if not exclusively, fact-based, and which must be assessed on a case-by-case basis. In the instant case, therefore, whether CARLE or HAMP is an ERISA fiduciary depends upon their role in the management and administration of the subject health plan – an issue which seems difficult to fully and appropriately determine solely upon the allegations of Amended Count III. That one of those entities, *i.e.*, HAMP, owns and operates an HMO, and that the other, *i.e.*, CARLE, owns HAMP, are facts meaningless to the question as to whether they are ERISA fiduciaries. To be clear, the business structure and purpose of an MCO, of an MCO's owner, and of an MCO's owner's parent corporation cannot alone transform any of these entities into an ERISA fiduciary, because that structure and purpose does not *per se* involve the administration or management of an employee benefit plan. Likewise, a physician's professional obligations to a patient cannot itself possibly create ERISA fiduciary obligations, because patient care and treatment is wholly removed from the process of administering and managing an employee health plan.

D. Are CARLE and HAMP Sufficiently Alleged to be ERISA Fiduciaries?

As noted above, this case reaches this Court on the propriety of the Seventh Circuit's reversal of the district court

dismissal under Rule 12(b)(6) of Herdrich's Amended Count III. The actual issue on appeal, therefore, is not whether CARLE and HAMP are, in fact, ERISA fiduciaries, but, rather, whether Herdrich *sufficiently alleged* that these entities are ERISA fiduciaries, *i.e.*, that they had or exercised any discretionary authority, control or responsibility in the management or administration of the subject health plan. The only way in which to reverse the Seventh Circuit on this issue, therefore, is if this Court determines that Herdrich failed to satisfy the federal pleading requirements in her Amended Count III, or if this Court concludes that, regardless of her allegations, neither CARLE nor HAMP can be an ERISA fiduciary as a matter of law. The ACLM and the Selfs aver that this Court should not make either of those findings.

In Herdrich's Amended Count III, as set out in the Petitioners' brief and the Seventh Circuit's opinion, she alleged the existence of an ERISA health plan (at ¶6), the employer's delegation of the function of administering the plan to the Amended Count III defendants (at ¶¶6 and 7), those defendants' discretionary authority and control over claims management, property management and asset management and the administration of the plan (¶¶7 and 8), and the charge that the defendants are, in fact, plan fiduciaries through the discharge of various tasks (¶11). The ACLM and the Selfs respectfully submit that Herdrich has satisfied liberal federal pleading requirements.

Finally, this Court should *not* find that CARLE and HAMP cannot be ERISA fiduciaries as a matter of law. As shown above, any entity or person who has or exercises any discretionary authority, control or responsibility in the management or administration of an ERISA plan is an ERISA fiduciary. Whether CARLE or HAMP possessed such authority, control or responsibility is a question of fact which

should not be resolved on the pleadings alone under a Rule 12(b)(6) motion to dismiss.³

E. Conclusion

For the foregoing reasons, the ACLM and the Selfs respectfully submit that the first issue on appeal is whether Herdrich sufficiently alleged that CARLE and HAMP are ERISA fiduciaries – a question which, at this stage of her lawsuit, should be answered in the affirmative.

II. THE SUBJECT COST-CONTAINMENT MECHANISM DIVIDES PHYSICIANS' LOYALTY TO PATIENTS

In the course of treatment, the physician is obligated to the patient and to no one else.... He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, nor of future sufferers from the same disease.... The physician is bound not to let any other interest

³ Notwithstanding Petitioners' argument to this Court, the fact that CARLE and/or HAMP may be ERISA fiduciaries is significantly advanced by their own prior pleadings in this case. After the Amended Count III defendants removed the case to federal court, Herdrich filed a motion to remand to state court. In response to that motion, Petitioners filed a brief arguing in favor of preemption, and thus, removal, in which brief they *admitted* that they are ERISA fiduciaries: "[HAMP] was the administrator and fiduciary of the Plan within the meaning of ERISA ... [and] it is clear that the plaintiff's claims relate to the Plan administered by [HAMP]. But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and [HAMP's] serving as administrator/ fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and [HAMP], and thus no lawsuit." See Memorandum in Opposition to Plaintiff's Motion to Remand, "Synopsis of Relevant Facts" (emphasis supplied). Petitioners, or at least Petitioner HAMP, is hard-pressed to argue now that, as a matter of law, it cannot be an ERISA fiduciary.

interfere with that of the patient in being cured.... We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.

Jonas, H., "Philosophical Reflections on Experimenting with Human Subjects," *Contemporary Issues in Bioethics* 432, 438 (T.L. Beauchamp and L. Walters, eds., 3rd ed. 1978).

In contrast to traditional fee-for-service medicine, "managed care creates a new adversarial relationship between the health care system and the patient." Patients want to know not only that the doctor is in, but which side the doctor is on.

Sage, W., "Physicians as Advocate," 35 *Hous.L.Rev.* 1529, 1534 (Spring, 1999), *quoting* Mehlman, M.J., "Medical Advocates: A Call for a New Profession," *Widener L.Symp.J.* 299, 305 (1996).

The ACLM and the Selfs believe firmly that the financial incentives at issue in this appeal necessarily infringe upon a physician's duty of loyalty to patients, and, in turn, hinder a physician's obligation to provide quality healthcare. It is simply implausible that any physician, regardless of his or her ethical standards, is unimpeded in medical decision-making where that physician will receive a cash reward for rendering less treatment, whether that reward is earned by omitting a diagnostic test or by not referring the patient to a specialist or treatment facility outside that physician's MCO network.

Notwithstanding the fact that the physician-patient relationship and a physician's obligation to the patient are genuinely unique and not easily amenable to analogy, consider the following:

Both physicians and jurists possess a fundamental duty of loyalty to their constituents – be they patients or litigants – to make fair and impartial decisions, and both are entrusted with significant responsibility by the systems in which they practice their craft. Now, imagine that, to off-set sky-rocketing costs of the federal justice system, Congress, or the federal judiciary itself, enacted a cost-containment mechanism pursuant to which the government paid a bonus to federal district court judges for minimizing the number of cases on their dockets. The goal of such a mechanism could be described as reasonable, if not noble, since the fewer cases there are to clog the justice system, the swifter justice could be for all litigants – just as the goal of cost-containment in managed care is reasonable, not only due to the for-profit, private nature of the system, but also because, in managed care, reduced costs for any particular patient is supposed to reduce the overall cost to all patients.

Now, in the analogy, what judge, in hearing a particular lawsuit, could wholly eliminate from contemplation a cash bonus to be earned if he or she renders a ruling that concludes the lawsuit? The ACLM and the Selfs do not for a moment suggest that some, most or all federal judges are vulnerable to such a proposed "incentive" program, nor that they would place personal financial gain over the administration of justice. Similarly, these *amici* feel confident that the vast majority of physicians are not driven by financial gain over patient care. However, complete disregard of a possible cash incentive by either group of professionals seems highly improbable, if not impossible.

Would such an incentive, whether for the physician or the jurist, influence every situation? Surely not, as both judges and physicians face what might be labeled "black and white" situations. Making the right decision in those cases is likely easy for the ethical physician or jurist. But consider the "gray area" cases, which may constitute the majority of cases for

doctors and judges. The ACLM and the Selfs submit that, even for the most ethical physician or jurist, it would be literally impossible to wholly disregard the fact that a cash bonus hinged on a professional decision.

Furthermore, the cost-containment mechanism at issue in this lawsuit essentially transforms physicians into health insurers. Where a physician decides to order a diagnostic test, or to bring an "outside" physician into the treatment process, the physician ultimately pays for that care by foregoing whatever cash incentive would have been earned without the test or referral. This analogy similarly illustrates how it would be virtually impossible to disregard the financial consequences to the physician of ordering a test or making a referral.

To be clear, the ACLM and the Selfs do not thrust their criticism generally upon all cost-containment mechanisms utilized in managed care. In this regard, the Seventh Circuit did *not* hold that cost-containment mechanisms *per se* violate ERISA:

Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists.

154 F.3d 362, 373. MCOs, like most if not all businesses, employ a variety of methods to reduce or eliminate unnecessary costs. However, mechanisms which reward physicians for *minimizing* care and treatment are simply in another category, and gnaw at the very core of physicians' professional obligation to their patients. As one physician-commentator recently noted:

The profit incentives underlying proposed cost cutting mechanisms have gradually, yet substantially, displaced the patient's best interest. ... [T]he key restraint for physicians ... is the limitation placed on the autonomy of their clinical judgment, a limitation which alters their role from serving as agents for the patient's welfare to balancing the patient's needs against the need for cost control. [T]hese recent developments place the essential element of the physician-patient relationship, advocacy, at risk of being permanently disrupted.

* * * * *

[M]anaged care entities critically rely upon the physician gatekeepers for their profit margins and overall financial stability. ... [G]rowing influence by MCOs over a physician's delivery of health care, as well as the latter's own financial incentives to underutilize medical resources, may bias physicians' judgment and risk the inappropriate denial of necessary services.

Gonzalez, J.L., "A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World," 35 *Hous.L.Rev.* 715, 717-18, 732 (Fall, 1998).

There should be no doubt that cash rewards paid to physicians to minimize care and treatment most assuredly work against the interest of patients.⁴

⁴ Interestingly, in a recent six-year comprehensive study involving of 3500 renal disease patients, a team of scientists determined that there are increased mortality rates and decreased rates of placement on waiting lists for renal transplants at *for-profit* dialysis facilities as compared to their *not-for-profit*

The foregoing argument may lead one to wonder why the ethical physician would ever agree to such a financial incentive. While it is true that such incentives are set forth in contracts between MCOs and physicians or physicians groups, it must be emphasized that these are far from negotiated terms arising out of evenly balanced contractual negotiations between managed care entities and their affiliated physicians. It is well-documented that MCOs dominate these negotiations, due primarily to the facts that economic survival requires physicians to affiliate with MCOs,⁵ and that many MCOs are enormous, and can afford simply to offer physicians "take-it-or-leave-it" contracts.⁶ Rarely, if ever, does a physician request that a portion of compensation be paid in the form of a bonus for minimizing treatment. These incentives are imposed upon physicians as a term of doing business with a particular MCO.

The ACLM and the Selfs take no position on whether the imposition of the cost-containment mechanism at issue in

counterparts. Garg, P., *et al.*, "Effect of the Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation," 341 *N.Eng.J.Med.* Vol. 341, No. 22 at pp. 1653-1660 (Nov. 1999).

⁵ In 1988, 61% of all physicians in the United States were contractually affiliated with at least one MCO - a percentage which rose to 75% in 1993, to 81% in 1996, and to 92% in 1997. "The Impact of Managed Care on Physicians," *Health Care Management Review*, Vol. 24, No. 2, p. 44 (March 22, 1999); "Managed Care Accounts for Greater Share of Physicians' Incomes," *Strategic Medicine*, Vol. 2, No. 5 (May, 1998).

⁶ See, e.g., various articles addressing MCOs' dominance over physicians in structuring their contractual affiliation: "Rebellion in White: Doctors Pulling Out of HMO Systems," *New York Times*, sec. 1, p. 1 (January 10, 1999); "Fiercer Aetna Sets its Sights on Dominating Health Care," *New York Times*, sec. C, p. 1 (December 14, 1998); "Insurers Tighten Rules and Reduce Fees for Doctors," *New York Times*, sec. 1, p. 1 (June 28, 1998); "Doctors v. Aetna: Win a Battle, Lose the War?" *Medical Economics*, Vol. 75, No. 10 at pp. 52-70 (May 26, 1998); "Managed Care Contracts: Some Progress, But Problems Linger," *American Medical News*, Vol. 41, No. 3 (January 19, 1998); "Whose Calling the Health Care Shots?" *Business & Health*, Vol. 15, No. 10 at pp. 30-35 (October, 1997).

this appeal falls within the rubric of ERISA and the fiduciary responsibilities imposed thereunder. The ACLM and the Selfs strongly believe, though, that the subject financial incentives are contrary to patients' best interests – a conclusion which, if the incentives are imposed by an ERISA fiduciary, suggests some relation to that fiduciary's duties under ERISA. For example, at section 404(a), ERISA expressly requires fiduciaries to discharge their duties "solely in the interest of the participants and beneficiaries." 29 U.S.C. §1104(a)(1). This Court, in *Varity Corp. v. Howe*, 516 U.S. 489, 506-515, 116 S.Ct. 1065, 1074-79 (1996), interpreted this phrase to create for a plan participant a cause of action for breach of fiduciary duty under ERISA for decisions premised upon financial gain to the fiduciary at the expense of plan participants. That is at least analogous to the instant situation, where the subject cost-containment mechanism is clearly intended to create financial gain to the alleged fiduciary, and is imposed at the potential expense of plan participants.

The ACLM and the Selfs also reject Petitioners' argument that healthcare is a mere *indirect* benefit of a health plan. Mere membership in a plan is of no benefit whatsoever to a plan participant. The only purpose for which a participant enrolls in (and pays for) a health plan is to receive the benefit of healthcare. Accordingly, patient care is a *direct* benefit of an ERISA health plan, thereby further implicating ERISA in the instant issue.

The ACLM and the Selfs again emphasize that the subject mechanism may be inclusive of a breach of fiduciary duty under ERISA. Clearly, a plaintiff, here Herdrich, must prove that the alleged injury was proximately caused by the financial incentives, but that fact is plainly alleged in her Amended Count III (at ¶13). Because Herdrich's ERISA claim was dismissed on a Rule 12(b)(6) motion to dismiss, if this Court determines that the imposition of the subject financial incentives even plausibly falls within the rubric of ERISA, then

Amended Count III should be reinstated to afford Herdrich the opportunity to prove her allegations.

CONCLUSION

For all the foregoing reasons, *Amici Curiae* American College of Legal Medicine, Thomas W. Self, M.D. and Linda P. Self, R.N. respectfully request that this Honorable Court (i) affirm the Seventh Circuit Court of Appeals' finding that Respondent Cynthia Herdrich sufficiently alleged Petitioners Carle Clinic Association and Health Alliance Medical Plans, Inc. to be ERISA fiduciaries so as to survive a Fed.R.Civ.P. 12(b)(6) motion to dismiss, and (ii) consider the adverse impact that the subject cost-containment mechanism has on healthcare delivery, in ruling on whether the imposition of this mechanism may give rise to an ERISA claim for breach of fiduciary duty.

Respectfully submitted,

AMERICAN COLLEGE OF
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By: 

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October 26, 1999

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Carter G. Phillips, Esq.
 Sidley & Austin
 1722 Eye Street, N.W.
 Washington, D.C. 20006

Re: Patterson et al. v. Burroughs
 Request to file Amicus Brief

Dear Mr. Phillips:

I am writing to you in your capacity as counsel to one of the parties in the referenced lawsuit.

I am co-chair of the Amicus Curiae Committee of the American College of Legal Medicine ("ACLM"). I am writing on behalf of the ACLM and Dr. & Mrs. Thomas Self. Pursuant to Supreme Court Rule 37(3)(a), I request your consent to allowing them to appear and file a brief as amicus curiae, favoring affirmance of the Seventh Circuit's decision in this case.

The ACLM, founded in 1980, is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of about 1400 professionals, including physicians and scientists in most every specialty, management and employees in various business fields, and plaintiff, defense, corporate and public interest attorneys. A large majority of the ACLM's membership, including all of that entity's Fellows, hold professional degrees in both law and medicine.

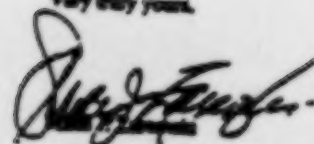
Dr. Self is a pediatric gastroenterologist (trained at Yale and UCLA) and Mrs. Self is a nurse both reside in San Diego.

I would appreciate your prompt consent to this request. Please sign this letter below and return it to my attention at 300 N. LaSalle Street, Suite 1500, Chicago, Illinois, 60601. My direct fax number is 312-630-7322. Of course, should you need any additional information from me with respect to those which I have been asked to represent here and/or their position in this matter, please do not hesitate to contact me.

A

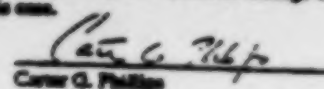
Thank you.

Very truly yours,



MZZ/cvt

I, Carter G. Phillips, counsel of record for the Petitioner in the above-captioned matter, hereby consent to the filing of an amicus curiae brief by the American College of Legal Medicine and Dr. & Mrs. Thomas Self in this case.


Carter G. Phillips



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Gary L. Susskind
Health Alliance Medical Plaza, Inc.
102 East Main Street
Urbana, IL 61801

Re: *Peterson et al. v. Harborth*
Request to file Amicus Curiae Brief

Dear Mr. Susskind:

I am writing to you in your capacity as counsel to one of the parties in the referenced lawsuit.

I am co-chair of the Amicus Curiae Committee of the American College of Legal Medicine ("ACLM"). I am writing on behalf of the ACLM and Dr. & Mrs. Thomas Self, Petitioner to Supreme Court Rule 370(a). I request your consent to allowing them to appear and file a brief as amicus curiae, favoring affirmance of the Seventh Circuit's decision in this case.

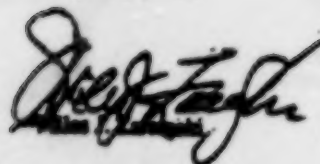
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Dr. Self is a pediatric gastroenterologist (trained at Yale and UCLA) and Mrs. Self is a nurse; both reside in San Diego.

I would appreciate your prompt consent to this request. Please sign this letter below and return it to my attention at 283 N. LaSalle Street, Suite 1500, Chicago, Illinois, 60601. My direct fax number is 312-430-7332. Of course, should you need any additional information from me with respect to those which I have been asked to represent here and/or their position in this matter, please do not hesitate to contact me.

Thank you.

Very truly yours,



MJZ/cvt

I, Gary L. Seditz, counsel of record for the Petitioner in the above-captioned matter, hereby consent to the filing of an amicus curiae brief by the American College of Legal Medicine and Dr. & Mrs. Thomas Self in this case.


Gary L. Seditz

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James P. Ginzkey
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Re: Pratt v. M. V. Hendrich
Request to file Amici Curiae Brief

Dear Mr. Ginzkey:

I am writing to you in your capacity as counsel to one of the parties in the referenced lawsuit.

I am co-chair of the Amicus Curiae Committee of the American College of Legal Medicine ("ACLM"). I am writing on behalf of the ACLM and Dr. & Mrs. Thomas Self. Pursuant to Supreme Court Rule 37(3)(a), I request your consent to allowing them to appear and file a brief as amici curiae, favoring affirmance of the Seventh Circuit's decision in this case.

The ACLM, founded in 1960, is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of about 1400 professionals, including physicians and scientists in most every specialty, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. A large majority of the ACLM's membership, including all of that entity's Fellows, hold professional degrees in both law and medicine.

Dr. Self is a pediatric gastroenterologist (trained at Yale and UCLA) and Mrs. Self is a nurse; both reside in San Diego.

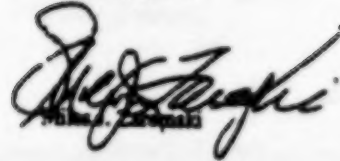
I would appreciate your prompt consent to this request. Please sign this letter below and return it to my attention at 203 N. LaSalle Street, Suite 1500, Chicago, Illinois, 60601. My direct fax number is 312-430-7322. Of course, should you need any additional information from me with respect to those which I have been asked to represent here and/or their position in this matter, please do not hesitate to contact me.

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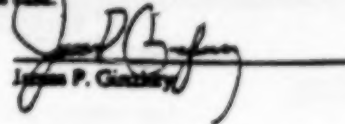
Thank you.

Very truly yours,


William J. McDonald

MJZ/evt

I, James P. Ginzkey, counsel of record for the Respondents in the above-captioned matter, hereby consent to the filing of an amicus curiae brief by the American College of Legal Medicine and Dr. & Mrs. Thomas if in the case.


James P. Ginzkey

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No. 98-1949

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IN THE
SUPREME COURT OF THE UNITED STATES

**LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,**
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari To The
United States Court of Appeals
For the Seventh Circuit

**BRIEF AMICI CURIAE OF AARP, NATIONAL
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NATIONAL SENIOR CITIZENS LAW CENTER
IN SUPPORT OF NEITHER PARTY**

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(continued on inside cover)

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Counsel for *Amicus Curiae* NSCLC

QUESTIONS PRESENTED ^{1/}

1. Is federal court jurisdiction lacking because Ms. Herdrich's original state law claims could not be brought under § 502(a) of ERISA's civil enforcement provisions inasmuch as Petitioners were not acting in any ERISA capacity?
2. If this Court has jurisdiction and finds that Ms. Herdrich's allegations present cognizable claims under ERISA's fiduciary rules, are ERISA fiduciaries liable to employee benefit plans, under ERISA § 502(a)(2), for restitution of bonuses and profits gained by committing fiduciary breaches?

^{1/} Although *amici* will not focus on the ostensibly narrow question presented in the Petition for Writ of Certiorari, the issues of jurisdiction, preemption and remedies are subsumed within the original question presented. In addition, they were raised, briefed, and decided below, and we believe that the district court rulings on these issues were erroneous. See Supreme Court Rule 14.1(a) ("[t]he statement of any question presented is deemed to comprise every subsidiary question fairly included within"); Supreme Court Rule 24.1(a) (in its discretion, the Court "may consider a plain error not among the questions presented but evident from the record and otherwise within its jurisdiction to decide").

TABLE OF CONTENTS

	<u>Page</u>
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF <i>AMICI CURIAE</i>	1
STATEMENT OF THE CASE	3
SUMMARY OF ARGUMENT	6
ARGUMENT	7
I. BECAUSE RESPONDENT'S STATE LAW CLAIMS CANNOT BE BROUGHT UNDER ERISA'S CIVIL ENFORCEMENT PROVISIONS WHERE PETITIONERS ARE MERELY ACTING AS HEALTH CARE SERVICE PROVIDERS TO AN ERISA PLAN, THERE IS NO FEDERAL COURT JURISDICTION	7
A. Proper Removal of a State Law Claim Requires That It Can Be Brought under Section 502(a) of ERISA	8
B. HMOs Are Not Subject to Suit under Section 502(a) of ERISA Where They Act as Providers of Health Care Services and Not as an ERISA Plan or in Any Other ERISA Capacity	9
C. Where HMOs Act as Medical Entrepreneurs Rather than in an ERISA Capacity, There Is No ERISA-Governed Relationship and State Laws Regulating Them as Such Are Not Preempted By Section 514(a) of ERISA	14

II. ERISA FIDUCIARIES ARE LIABLE TO THE PLAN FOR RESTITUTION OF BONUSES AND PROFITS WHICH THEY GAIN BY THEIR COMMISSION OF FIDUCIARY BREACHES ...	19
CONCLUSION	23

TABLE OF AUTHORITIES

CASES

<i>Airparts Co. v. Custom Benefit Services</i> , 28 F.3d 1062 (10th Cir. 1994)	17
<i>Amalgamated Clothing & Textile Workers v. Murdock</i> , 861 F.2d 1406 (9th Cir. 1988)	20, 21, 22
<i>American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.</i> , 973 F. Supp. 60 (D. Mass. 1997)	11, 12
<i>Anderson v. Humana, Inc.</i> , 24 F.3d 889 (7th Cir. 1994)	18
<i>Arizona State Carpenters Pension Trust Fund v. Citibank</i> , 125 F.3d 715 (9th Cir. 1997)	17, 18
<i>Bast v. Prudential Insurance Co.</i> , 150 F.3d 1003 (9th Cir. 1998), <i>cert. denied</i> , 120 S. Ct. 170 (1999) ...	20
<i>Blue Cross of California v. Anesthesia Care Associates</i> , 187 F.3d 1045 (9th Cir. 1999)	10, 12, 13
<i>Boggs v. Boggs</i> , 520 U.S. 833 (1997)	3
<i>California Division of Labor Standards Enforcement v. Dillingham Construction</i> , 519 U.S. 316 (1997)	3, 15, 15, 18
<i>Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.</i> , 472 U.S. 559 (1986)	20
<i>Cippolone v. Liggett Group</i> , 505 U.S. 504 (1992)	18
<i>Coyne & Delany Co. v. Selman</i> , 98 F.3d 1457 (4th Cir. 1996)	10, 17, 18
<i>Custer v. Sweeney</i> , 89 F.3d 1156 (4th Cir. 1996)	17, 18
<i>De Buono v. NYSA-ILA Med. & Clinical Services Fund</i> , 520 U.S. 806 (1997)	3, 7, 15, 16
<i>Donovan v. Bierwith</i> , 680 F.2d 263 (2d Cir. 1982)	21
<i>Donovan v. Dillingham</i> , 688 F.2d 1367 (11th Cir. 1982)	12
<i>Dukes v. U.S. Healthcare</i> , 57 F.3d 350 (3rd Cir. 1995), <i>cert. denied</i> , 116 S. Ct. 1876 (1996)	13, 16
<i>Eaves v. Penn</i> , 587 F.2d 453 (10th Cir. 1978)	21
<i>Franchise Tax Board Of California v. Construction Laborers Vacation Trust for Southern California</i> , 463 U.S. 1 (1983)	9
<i>Geissal v. Moore Medical Corp.</i> , 118 S. Ct. 1869 (1998)	3
<i>Herdrich v. Pegram</i> , 154 F.3d 362 (7th Cir. 1998) ..	<i>passim</i>
<i>Hospice of Metropolitan Denver, Inc. v. Group Health Insurance of Okla., Inc.</i> , 944 F.2d 752 (10th Cir. 1991)	17
<i>Ingersoll-Rand v. McClendon</i> , 498 U.S. 133 (1990)	8
<i>In re U.S. Healthcare</i> , ___ F.3d ___, 1999 WL 728474 (3rd Cir. 1999)	9, 10, 13
<i>Inter-Modal Rail Employees Association v. Atchison, Topeka & Santa Fe Railway Co.</i> , 520 U.S. 510 (1997)	3
<i>John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank</i> , 510 U.S. 86 (1993)	17
<i>LeBlanc v. Cahill</i> , 153 F.3d 134 (4th Cir. 1998)	17

<i>Leigh v. Engle</i> , 727 F.2d 113 (7th Cir. 1984)	21
<i>Louisville & Nashville R. Co. v. Mottley</i> , 211 U.S. 149 (1908)	7
<i>Lupo v. Human Affairs International Inc.</i> , 28 F.3d 269 (2d Cir. 1994)	16
<i>Mackey v. Lanier Collections Agency & Service</i> , 486 U.S. 825 (1988)	18
<i>Massachusetts Mutual Life Insurance Co. v. Russell</i> , 473 U.S. 134 (1985)	14, 20
<i>Memorial Hospital System v. Northbrook Life Insurance Co.</i> , 904 F.2d 236 (5th Cir. 1990)	17
<i>Mertens v. Hewitt Associates</i> , 508 U.S. 248 (1993)	20, 21
<i>Metropolitan Life Insurance Co. v. Taylor</i> , 481 U.S. 58 (1987)	8, 9, 14
<i>Morstein v. National Insurance Services, Inc.</i> , 93 F.3d 715 (11th Cir. 1996)	19
<i>New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.</i> , 514 U.S. 645 (1995)	14, 18
<i>Pacificare of Oklahoma, Inc. v. Burrage</i> , 59 F.3d 151 (10th Cir. 1995)	16
<i>Pappas v. Asbel</i> , 724 A.2d 889 (Pa. Supreme Ct. 1998), petition for cert. pending, sub. nom. <i>United States Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Co., et al.</i> , 67 U.S.L.W. 3717 (May 13, 1999)	16
<i>Perkins v. Time Insurance Co.</i> , 898 F.2d 470 (5th Cir. 1990)	19

<i>Rice v. Panchal</i> , 65 F.3d 637 (7th Cir. 1995)	8, 14, 16
<i>Shaw v. Delta Air Lines</i> , 463 U.S. 85 (1983)	15
<i>Strom v. Goldman, Sachs & Co.</i> , 1999 WL 639844 (No. 98-7090) (2d Cir. Aug. 24, 1999)	20
<i>Sumner v. Mata</i> , 449 U.S. 539 (1981)	7
<i>Toumajian v. Frailey</i> , 135 F.3d 648 (9th Cir. 1998) ...	8, 14
<i>UNUM v. Ward</i> , 119 S. Ct. 334 (1999)	3
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	3
<i>Waller v. Blue Cross of California</i> , 32 F.3d 1337 (9th Cir. 1994)	22
<i>Washington Physicians Service Associate v. Gregoire</i> , 147 F.3d 1039 (9th Cir. 1998)	11
<i>Wilson v. Zoellner</i> , 114 F.3d 713 (8th Cir. 1997)	19
<i>Woodworker's Supply, Inc. v. Principal Mutual Life Insurance Company</i> , 170 F.3d 985 (10th Cir. 1999) ...	19

STATUTES AND RULES

ERISA, 29 U.S.C. § 1001 <i>et seq.</i>	3, 5
§ 3, 29 U.S.C. § 1002(21)	13
§ 409, 29 U.S.C. § 1109	20, 23
§ 502, 29 U.S.C. § 1132	5
§ 502(a), 29 U.S.C. § 1132(a)	<i>passim</i>
§ 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)	10
§ 502(a)(2), 29 U.S.C. § 1132(a)(2)	i, 7, 20, 21
§ 502(a)(3), 29 U.S.C. § 1132(a)(3)	21
§ 502(e), 29 U.S.C. § 1132(e)	8
§ 502(e)(1), 29 U.S.C. § 1132(e)(1)	8
§ 514, 29 U.S.C. § 1144	5, 6, 11
§ 514(a), 29 U.S.C. § 1144(a)	<i>passim</i>

Supreme Court Rule 14.1(a)	i
Supreme Court Rule 24.1(a)	i
Supreme Court Rule 37.3	3

MISCELLANEOUS

G. T. Bogert, <i>Trusts, Creation of Constructive Trusts</i> (6th ed. 1987)	
§ 86	21
§ 87	21

Karen A. Jordan, <i>Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption</i> , 13 YALE J. REG. 255 (1996)	12
---	----

RESTATEMENT (FIRST) OF RESTITUTION (1936)	
§ 138(1)	21
§ 160	21
§ 197	21, 22

RESTATEMENT (THIRD) OF TRUSTS (1990)	
§ 205(a)	21

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1998

**LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,**
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

**ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

**BRIEF AMICI CURIAE OF AARP, NATIONAL
EMPLOYMENT LAWYERS ASSOCIATION AND
NATIONAL SENIOR CITIZENS LAW CENTER
IN SUPPORT OF NEITHER PARTY**

INTEREST OF AMICI CURIAE ^{2f}

Three national organizations join in this brief which focuses on two issues -- first, whether the federal court lacked jurisdiction over Ms. Herdrich's original state law claims because those claims cannot be brought pursuant to the Employees Retirement Income Security Act's (ERISA) civil enforcement provisions, and second, if there is federal court jurisdiction, whether ERISA fiduciaries are liable to employee benefit plans for restitution of bonuses and profits gained by

^{2f} No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

committing fiduciary breaches. As the following descriptions of these organizations demonstrate, they have a significant interest in the outcome of this case.

AARP is a nonprofit membership organization of more than 33 million Americans age 50 or older, dedicated to addressing the needs and interests of older people. Approximately one-third of AARP's members are working and rely on employer-funded health benefits for their health coverage. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling its costs without compromising quality.

The National Senior Citizens Law Center (NSCLC) is a nonprofit organization that advocates on behalf of elderly poor people. Since its formation in 1972, NSCLC has engaged in judicial, legislative and administrative advocacy, technical assistance, and training in many areas of elder law, including health care. NSCLC has brought numerous law suits on behalf of ERISA-covered beneficiaries to protect their rights under that federal statute and its implementing regulations.

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of over 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of lawyers who primarily represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.

Each of the *amici* organizations thus advocates on behalf of individuals throughout the country to protect the rights of

individuals who are participants in private, employer-sponsored employee benefit plans covered by ERISA, 29 U.S.C. § 1001 *et seq.* For instance, AARP and NELA have filed numerous briefs *amicus curiae*, both jointly and singly, on the interpretation of ERISA's preemption clause, including in *UNUM v. Ward*, 119 S. Ct. 334 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), as well as in other types of ERISA cases. See, e.g., *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998) (COBRA rights); *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997) (application of ERISA § 510 to welfare plans); *Varity Corp. v. Howe*, 516 U.S. 489 (1996) (participant rights under ERISA § 502(a)(3)).

The decision in this case will have a direct and vital bearing on the quality of health care that older working Americans receive. In light of the significance of the issues presented by this case, *amici curiae* respectfully submit this brief.^{3/}

STATEMENT OF THE CASE

Dr. Lori Pegram, a Carle Clinic Association physician, examined Cynthia Herdrich and determined that she had an inflamed mass in her abdomen. Carle Clinic, a medical corporation owned by its physician-shareholders, generally required that its HMO patients receive diagnostic tests only from Carle-owned facilities. Petition for Writ of Certiorari (Pet.) 3 & 4, n.1. While Ms. Herdrich waited eight days to obtain an ultrasound at a Carle Clinic facility, her appendix ruptured. *Herdrich v. Pegram*, 154 F.3d 362, 374 (7th Cir. 1998).

Ms. Herdrich sued Dr. Pegram and Carle Clinic in state court alleging two counts of medical malpractice and later added two other counts against Carle Clinic and Health Alliance Medical

^{3/} The written consents of the parties have been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

Plans (HAMP). Pet. 4. HAMP is a health maintenance organization (the HMO), a prepaid insurance plan which contracted with State Farm Insurance Company to provide Ms. Herdrich's health care through Carle Clinic. HAMP's sole shareholder is Carle Clinic. Pet. 3. Count III alleged that Carle Clinic violated the Illinois Consumer Fraud Act by failing to reveal to Ms. Herdrich that the Carle Clinic physicians hired by HAMP in fact owned HAMP and by failing to inform her that Carle doctors earned bonuses based upon the amount of profits generated by not making emergency or consultation referrals, by not ordering diagnostic tests, and by requiring patients to use only Carle-owned facilities. Respondents' Brief in Opposition, Appendix (Res. App.) 25a. Count IV alleged HAMP breached its state law contractual duties of good faith and fair dealing by limiting tests and referrals to the detriment of its patients in order to increase its profits. *Herdrich*, 154 F.3d at 366, n. 2.

Petitioners removed the case to federal court claiming that Counts III and IV were preempted by § 514(a) of ERISA (29 U.S.C. § 1144(a)) because Ms. Herdrich's health care was paid for by her husband's employer, State Farm Insurance Company. Res. App. 24a. Respondent moved for remand, arguing the claims were not preempted. Pet. App. 66a. The court ruled that Count IV was preempted on the basis that it was related to an ERISA plan, left open the question of Count III, and denied remand. *Id.* at 68a; Res. App. 8a. Subsequently, ruling on Petitioners' motion for summary judgment on Counts III and IV, the district court also held Count III was preempted under the Supreme Court's "broad interpretation of the 'relate[s] to' requirement." Pet. App. 77a. The court held because ERISA "comprehensively regulates the necessary disclosures," Count III "relate[d] to an employee benefit plan, and as such is preempted" under § 514. *Id.* at 77a and 79a. The court then ordered Ms. Herdrich to amend Count III to allege a cause of action under ERISA or face dismissal with prejudice. *Id.* at 79a-80a. The court stated that "[h]aving found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be [sic] provide a cause of action for Plaintiff. The availability of a federal remedy does

not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA." *Id.* at 79a.⁴⁷

Following that Order, Ms. Herdrich amended Count III to allege that Carle Clinic, HAMP and Carle Health Insurance Management Co. (CHIMCO), a management entity solely owned by Carle Clinic, breached fiduciary duties under ERISA. Pet. App. 83a-87a; Pet. 3. Ms. Herdrich asked that the court order Carle Clinic to reimburse the Plan for the "supplemental medical expense payments received from HAMP and CHIMCO," and for "other equitable relief." Pet. App. 87a. Petitioners moved to dismiss Amended Count III for failure to state a claim under ERISA. *Herdrich*, 154 F.3d at 367. The district court granted that motion on the ground that "plaintiff fails to identify how any of the defendants is involved as a fiduciary to the plan." Pet. App. 63a.⁴⁸

On appeal, the Seventh Circuit ruled Amended Count III was sufficient to withstand a motion to dismiss. Ms. Herdrich's allegations that Petitioners had the exclusive right to decide all disputed and non-routine claims enabled the court to "reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims." 154 F.3d at 370. The Seventh Circuit also held that

⁴⁷ Whether or not the district court was correct in its assertion as to preemption, it was incorrect with regard to the question of whether removal was proper. As discussed in the text *infra*, the propriety of removal depends on the existence of an ERISA claim under 29 U.S.C. § 1132, not on preemption under 29 U.S.C. § 1144.

⁴⁸ In arguing for preemption, Petitioners stated HAMP "was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. § 1001 *et seq.*)." Res. App. 24a. The district court noted that throughout the litigation, Petitioners represented that they were all fiduciaries of the ERISA plan, but the district court did not expressly make such a finding. Pet. App. 69a. On appeal, Petitioners did not argue that they were not fiduciaries, but instead, argued the appeal was not timely and that Herdrich's request for damages was inappropriate because ERISA beneficiaries "may not recover 'anything other than the benefits provided expressly in the plan.'" *Herdrich*, 154 F.3d at 367.

"plan beneficiaries have standing to bring an action on behalf of the plan to recoup monies in violation of ERISA," and that Ms. Herdrich "alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants' actions." *Id.* at 380. The appeals court explicitly held that the mere existence of financial incentives to limit care does not automatically give rise to a breach of fiduciary duty, but that "incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)." *Id.* at 373. The case was remanded to give Ms. Herdrich the opportunity to prove all the elements of her claims at trial. *Id.* at 380.

SUMMARY OF ARGUMENT

Because Ms. Herdrich sued Carle Clinic physicians and the HMO they own for actions they took in running their health care business, rather than for actions they took as fiduciaries administering or managing an ERISA plan, the district court erred when it ruled that the case was properly removed because ERISA preempted her state law claims for violation of the Illinois Consumer Fraud Act and breach of the duty of good faith and fair dealing. These claims cannot be brought under ERISA's civil enforcement provisions, which are set forth in ERISA § 502, 29 U.S.C. § 1132(a). Therefore, ERISA does not provide federal court jurisdiction over her state law claims, and removal of these claims from state court was improper.

Although § 514 of ERISA is not directly implicated in this case, this Court's recent analysis of that provision demonstrates that the state law claims at issue here are not the types of claims which Congress intended to preempt under ERISA; ERISA was designed to regulate employee benefit plans, not the services which those plans purchase. The district court erred in forcing the plaintiff to replead her claims under ERISA, rather than remanding the state claims back to state court.

Amici ask the Court to address the question of whether the net of ERISA preemption was cast too widely in this case before reaching the issue of whether fiduciary liability under the statute has been stretched beyond Congress' intent as asserted in the Petition for Writ of Certiorari. Pet. 11. However, if the Court finds that original state law claims were displaced by ERISA's civil enforcement provisions and thus, federal court jurisdiction exists, and further, finds that the plaintiff has stated a cognizable claim under ERISA's fiduciary duty rules, the Court should find that disgorgement of profits to the plan is appropriate relief under ERISA § 502(a)(2).

ARGUMENT

I. BECAUSE RESPONDENT'S STATE LAW CLAIMS CANNOT BE BROUGHT UNDER ERISA'S CIVIL ENFORCEMENT PROVISIONS WHERE PETITIONERS ARE MERELY ACTING AS HEALTH CARE SERVICE PROVIDERS TO AN ERISA PLAN, THERE IS NO FEDERAL COURT JURISDICTION.

In its decisions, the district court concluded that the breadth of this Court's interpretation of ERISA's preemption clause warranted a conclusion that Ms. Herdrich's state law claims were preempted by § 514(a) (29 U.S.C. § 1144(a)). Pet. App. 77a and 79a (Count III); Res. App. 8a (Count IV). The court never held that it had jurisdiction under the civil enforcement provisions in ERISA § 502(a) (29 U.S.C. § 1132 (a)). Instead, the court assumed jurisdiction under § 514(a) and required Ms. Herdrich to replead her complaint under ERISA. Pet. App. 76a-79a. The court was wrong in its assumption of jurisdiction, an issue which was not reviewed by the Seventh Circuit.^{6/}

^{6/} This Court should address the question of subject matter jurisdiction, whether or not it has been preserved by the parties. *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 152 (1908). In *Sumner v. Mata*, 449 U.S. 539, 548, n. 2 (1981), this Court decided the underlying jurisdictional issue where, as in this case, jurisdiction was raised as an issue before the district court but abandoned before the court of appeals. See *De Buono v. NYSA-*

A. Proper Removal of a State Law Claim Requires That It Can Be Brought under Section 502(a) of ERISA.

Federal courts have concurrent jurisdiction with state courts over individual claims for benefits under the terms of an employee benefit plan, but federal courts alone have exclusive jurisdiction over all other claims authorized by ERISA § 502(a). ERISA § 502(e), 29 U.S.C. § 1132(e). Thus, in order to remove a state law claim, that claim must be displaced by ERISA's civil enforcement provisions under § 502(a). See *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990) (state wrongful discharge action completely displaced by ERISA § 510; therefore claim properly removed). If the state law claim cannot be brought under ERISA's civil enforcement provisions, then there is no federal question jurisdiction under ERISA and removal is improper. ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1). See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987) ("It is long-settled law that a cause of action arises under federal law only when the plaintiff's well pleaded complaint raise issues of federal law"); *Toumajian v. Frailey*, 135 F.3d 648 (9th Cir. 1998) (no removal unless claim is encompassed within ERISA's civil enforcement scheme); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (same).

Because, as discussed below, Ms. Herdrich's claims could not be brought under ERISA § 502(a), the district court did not have jurisdiction of this case and her claims were improperly removed. See *Metropolitan Life Ins. Co. v. Taylor*, *supra*; *Franchise Tax Bd. Of California v. Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 9-12 (1983) (federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint).

ILA Medical and Clinical Services Fund, 520 U.S. 806, 820 (1997) (Scalia, dissenting) (jurisdiction must be decided before merits are reached).

B. HMOs Are Not Subject to Suit under Section 502(a) of ERISA Where They Act as Providers of Health Care Services and Not as an ERISA Plan or in Any Other ERISA Capacity.

When an employer establishes an employee health benefits plan, there are a variety of ways it can structure the provision of those benefits to employees. Employers may implement a plan through the purchase of insurance, self-funding, and/or the use of service providers such as managed health care plans like HMOs or preferred provider organizations (PPOs). HMOs that contract with employers to provide health care services to employees through an ERISA plan can simultaneously play different roles in relation to that ERISA plan.

Many courts have recognized the different hats HMOs wear when providing managed health care for employee beneficiaries of ERISA plans. For example, in *In re U.S. Healthcare*, ___ F.3d ___, 1999 WL 728474 (3d Cir. 1999), the Third Circuit distinguished between the HMO as administrator of an ERISA plan and the HMO as provider of health care. The Third Circuit stated:

As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes* [57 F.3d 350 (3d Cir. 1995)], claims that fall within the essence of the administrator's activities in this regard fall within section 502(a)(1)(B) and are completely preempted.

In contrast . . . when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or through contracts with hospitals, doctors, or nurses. In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care.

Id. at *8 (citations omitted). In reviewing plaintiffs' claims in that case, the Third Circuit found that the HMO's policies and actions were taken in its capacity as a provider of medical care, not as a determiner of benefit eligibility. Accordingly, the HMO's presumptive policy of discharging newborns within twenty four hours of birth, as well as its policy of discouraging physicians from readmitting newborn infants, were policies adopted in providing and arranging medical services, policies "that adversely influenced the medical judgment of its participating physicians." *Id.* at *10. The Third Circuit also held that the allegation that the HMO was negligent in its selection, supervision and training of the employee-doctor was clearly one involving quality of care. ERISA did not preempt those claims because they "do not involve an attempt to recover benefits due, enforce rights, or clarify future benefits under a plan, but rather seek recovery under the quality standard found in the otherwise applicable [state] law." *Id.* at *10 (quotation and citation omitted).

Similarly, *Blue Cross of California v. Anesthesia Care Associates*, 187 F.3d 1045 (9th Cir. 1999), demonstrates the distinction between an HMO acting as a fiduciary in handling benefit claims and acting as an entrepreneur in its relationships as medical care contractors. At issue were whether claims for fees under a contract between health plans and medical providers were preempted by ERISA because they fell within the civil enforcement provisions of § 502(a) or related to a plan under ERISA's express preemption clause of § 514(a). The Ninth Circuit rejected the HMO's argument that this fee dispute was really a benefit claim under § 502(a)(1)(B). Instead, the court stated that "[t]he dispute here is not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment which depends on the terms of the provider agreements." *Blue Cross*, 187 F.3d at 1051. Moreover, merely because an ERISA plan is consulted in the course of litigating a state law claim does not cause the state law claim to be extinguished by ERISA. *Id.*; accord, *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1472 (4th Cir. 1996). The court in *Blue Cross* also found that these claims did not relate to ERISA plans under § 514 because "there is no contention here that the

economic impact will be so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage." *Blue Cross*, 187 F.3d at 1053. Nor did the providers' state law claims implicate any ERISA-governed relationship. Instead, the claims concerned contractual promises made by the HMO to its participating physicians. *Id.* at 1054. This decision clearly underscores the variety of functions that an HMO may perform and shows the necessity of reviewing the HMO's status in relation to the claim at issue on a case by case basis.

In a somewhat different context, *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), further illustrates the difference between an ERISA plan or plan fiduciary and a service provider to that plan. There, the Ninth Circuit found that a state's alternative provider statute did not have a significant connection with an ERISA plan because the statute required action solely by health providers; it did not require an ERISA plan to do anything. The statute only regulated and mandated benefits provided by insurers. The "mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it 'relates to' an ERISA plan." *Id.* at 1045.

American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60 (D. Mass. 1997), shows the necessity of looking beyond the bare conclusory allegations that an HMO is an ERISA-governed entity. American Drug Stores brought suit to gain admission to the restricted pharmacy network through which Harvard Pilgrim, an HMO, contracted to supply its patient-customers. Massachusetts' "any willing provider" statute required that Harvard Pilgrim, the carrier, permit any pharmacy to join its network as long as the non-network pharmacy agreed to the same terms as network pharmacies, but the statute did not dictate the terms of such agreements. In a thoughtful analysis of this Court's more recent preemption cases, the court held that Massachusetts' "any willing provider" statute was not preempted because "the organization and offering of restricted networks is part of the carrier's own administration rather than its administration of ERISA plans." *Id.* at 68. In reaching its decision, the court enumerated the "limited range of administrative functions which are part of

operating an employee benefit plan" – "eligibility determinations, benefit calculations, disbursements, fund monitoring or record keeping." *Id.* at 67. Moreover, the court concluded that even if a carrier performs some activities that amount to plan administration, not "everything carriers do for ERISA plans is entitled to the same protection."²¹ *Id.* citing Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. REG. 255, 303 (1996) (arguing for recognition of the distinction between ERISA functions and business functions).

As the above cases illustrate and Petitioners concede, Carle Clinic and HAMP serve multiple roles in their relationship to patients, ERISA plans, and third party payors. Pet. 19. While Petitioners may function as ERISA fiduciaries in some of their dealings with Respondent (e.g., if they decide whether a procedure is covered by the plan), in order to determine whether the state law claims at issue must be brought under ERISA's civil enforcement provisions, the Court must look at the state law claim itself and the role of the Petitioners in relation to that claim. *Blue Cross*, 187 F.3d at 1051; *American Drug Stores*, 973 F. Supp. at 67.

Here, State Farm is the employer which established and maintained a program of health benefits for its employees and their dependants. *See Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) ("a plan, fund or program falls within the ambit of ERISA only if the plan, fund, or program covers ERISA participants because of their employee status . . . and an employer . . . is the person that establishes or maintains the plan, fund, or program."). State Farm's employee benefits plan is the ERISA plan involved in this case. Carle Clinic and HAMP provide medical services to the ERISA plan; they are not the plan itself. State Farm pays for the services which Carle Clinic and HAMP provide to patients when those patients are State Farm employees, but that does not turn Carle Clinic's or HAMP's actions in running its own medical plan into actions

taken by an ERISA plan, nor does it turn Carle Clinic or HAMP into a fiduciary.²²

To the contrary, Petitioners were acting in their capacities as medical entrepreneurs, not as an ERISA plan or any other ERISA-governed entity. In instituting bonus policies for physicians, and in failing to inform Ms. Herdrich of those policies, Petitioners were not acting as administrators determining eligibility for benefits or as fiduciaries managing plan assets or other plan administration. ERISA § 3(21), 29 U.S.C. § 1002(21). Instead, the bonus arrangement between HAMP and Carle Clinic doctors is like the provider agreements in *Blue Cross*, contractual promises between the HMO and its participating physicians having only the most tenuous connection with an ERISA plan. *Blue Cross*, 187 F.3d at 1051. Petitioners admit that when "HMOs and other health care providers make myriad discretionary judgments . . . [m]any such judgments – including the cost-containment mechanism adopted – have no direct impact on the benefits provided by an ERISA plan." Pet. 11. This admission flatly shows that the Petitioners themselves do not believe that they were acting as ERISA fiduciaries when instituting the compensation policies which were challenged by Ms. Herdrich under state law. Like the HMO in *In re U.S. Healthcare*, Carle Clinic and HAMP instituted business policies which allegedly impacted the provision and arrangement of medical care in a manner which adversely affected the medical judgment of its physicians. *In re U.S. Healthcare*, at *10. In its preemption arguments, HAMP asserted that, if successful, Ms. Herdrich's state law claims would require HAMP to become the "guarantor of the quality of care paid for by the Plan." Res. App. 36a. ERISA's civil enforcement provisions simply do not address quality of care issues. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3rd Cir.1995).

²² "[A] person is a fiduciary with respect to a plan to the extent . . . he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or dispositions of its assets . . . or . . . he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21).

²¹ "[G]eneral state contract, zoning or tort legislation can surely affect the options available to ERISA plans without thereby being preempted." *American Drug Stores*, at 66.

HAMP and Carle Clinic could not have been sued in any ERISA capacity under any of the "six carefully integrated civil enforcement provisions" set forth in § 502(a) because the claims against Petitioners were for their actions in creating incentive arrangements which allegedly breached contractual duties owed to patients and for alleged unfair consumer trade practices, not actions taken in administering employee benefits or managing the plan's assets. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 n.3 (1985). Thus, Ms. Herdrich's state law claims could not be brought under ERISA's civil enforcement provisions, there was no federal court jurisdiction, and her state law claims were improperly removed to federal court. *Metropolitan Life Ins. Co.*, 481 U.S. at 63 (1987); *Toumajian*, 135 F.3d at 657; *Rice*, 65 F.3d at 646.

C. Where HMOs Act as Medical Entrepreneurs Rather than in an ERISA Capacity, There Is No ERISA-Governed Relationship and State Laws Regulating Them as Such Are Not Preempted By Section 514(a) of ERISA.

A review of this Court's recent cases interpreting ERISA's express preemption clause provides support for *amici's* position that there is no jurisdiction over this action.²⁷ With its unanimous decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), this Court signaled a shift in its ERISA preemption analysis. It held that courts must start with the presumption

²⁷ ERISA § 514(a), 29 U.S.C. § 1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." In its first ruling, the district court did not have the benefit of this Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), and its second ruling was made only three months after the first of these cases, *Travelers*. Instead, the district court relied solely upon *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), a case involving state mandated benefit laws, which are not at issue here.

"that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 655.¹⁰⁷

California Division of Labor Standards Enforcement v. Dillingham Construction, 519 U.S. 316 (1997), reinforced the presumption against preemption set forth in *Travelers*. In *Dillingham*, this Court held that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. *Id.* at 331. *Dillingham* reaffirmed that a state law only "relates to" an ERISA plan if it refers to or has a significant connection with an ERISA plan.

In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine whether the type of state law at issue is one that Congress would not have intended to preempt and then analyze the effect the state law has on ERISA plans. *Id.* at 332.

If ERISA were concerned with any state action--such as medical-care quality standards or hospital workplace regulations--that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's preemptive reach.

Id. at 329. Moreover, if the law merely "alters the incentives" which exist for an ERISA plan, "but does not dictate the choices," then the law is not sufficiently connected with an ERISA plan to require preemption. *Id.* at 333.

¹⁰⁷ This assumes of course that the state law does not refer to an ERISA plan or fall into one of the three types of state laws which are always preempted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. See *Travelers*, at 657-58, 660.

In *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), this Court emphasized the new preemption paradigm, concluding that any law “that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.” *Id.* at 816. Here, where the state law claims at issue invoke traditional areas of state concern and do not impact relationships regulated by ERISA, they are neither preempted nor form a proper basis for removal.

In keeping with this Court’s approach to ERISA preemption, the lower courts generally have found that medical malpractice claims against HMOs are not preempted and/or have been improperly removed from state court.^{11/} Moreover, medical malpractice claims against HMOs as medical service providers to ERISA plans are analytically indistinguishable from malpractice claims against other types of service providers to plans such as actuaries, attorneys and investment advisers.

^{11/} *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (claims against administrator of plan under theory of respondeat superior based on malpractice of provider on list designated by plan, not on negligent selection of that provider, did not provide basis for removal); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (vicarious liability claims against HMO based on malpractice of one of its treating physicians in treating patient were not preempted); *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 116 S. Ct. 1876 (1996) (medical negligence claims against HMO’s improperly removed); *Lupo v. Human Affairs International Inc.*, 28 F.3d 269 (2d Cir. 1994) (malpractice and breach of fiduciary duty claims based on doctor-patient relationship and infliction of emotional distress claim against managed psychotherapy care entity based on actions of its psychotherapist-employee improperly removed); *Pappas v. Asbel*, 724 A.2d 889 (Pa. Supreme Ct. 1998), *petition for cert. pending sub. nom. United States Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Co., et al.*, 67 U.S.L.W. 3717 (May 13, 1999) (No. 98-1836) (vicarious liability malpractice claim against HMO based on delay in transferring patient to an authorized facility was not preempted as “negligence laws have only a tenuous . . . connection with ERISA covered plans, . . . and therefore are not preempted”). (Internal punctuation and citations omitted.)

Courts have held repeatedly that state law claims against these non-fiduciary service providers are not preempted.^{12/}

The rationale for such results is obvious. Nothing in ERISA or its legislative history evinces a clear legislative intent to preempt traditional state laws of general applicability that do not affect the relations among the principal ERISA entities – the employer, the plan fiduciaries, the plan, and the beneficiaries. *See e.g., Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715, 724 (9th Cir. 1997); *Custer v. Sweeney*, 89 F.3d 1156, 1167 (4th Cir. 1996). When a state law does not regulate an ERISA-governed relationship, it will not be preempted.^{13/} *See id.; Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (law affecting the relations between an ERISA entity and an outside party is not preempted). Quite simply, if there is no regulation of an ERISA-governed relationship, more likely than not, there will be no significant effect on the structure, administration, or the type of benefits provided by the plan. *Id.*

Likewise, if the principal ERISA entities are not being regulated in their ERISA capacities, then there is no ERISA-governed relationship. *Arizona State Carpenters*, 125 F.3d at 724; *cf. John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 106 (1993) (an insurance company acting as an investment manager of plan assets must comply with fiduciary standards). Conversely, but analytically parallel,

^{12/} *See, e.g., LeBlanc v. Cahill*, 153 F.3d 134 (4th Cir. 1998) (investment adviser); *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715 (9th Cir. 1997) (bank as non-fiduciary plan asset custodian); *Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996) (insurance agent); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996) (attorney); *Airparts Co. v. Custom Benefit Services*, 28 F.3d 1062 (10th Cir. 1994) (consultant); *cf. Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990) (health care providers’ state law claims against plan not preempted).

^{13/} Courts generally only reach the issue of an ERISA-governed relationship after they determine that the state law at issue does not fall into one of the types of three state laws that are always preempted. *See supra*, n. 10.

this Court has recognized that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are against the plan in a capacity other than as a plan -- *i.e.*, as a commercial entity -- and are not preempted. *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 833 (1988).

None of Ms. Herdrich's original state law claims concern Petitioners acting in an ERISA capacity -- that is, these claims do not impact plan administration or the payment of benefits. Instead, Carle Clinic and HAMP are in the business of providing medical services and Ms. Herdrich is a consumer of such services. A provider-consumer relationship does not fit within the traditional ERISA relationships. Instead, the relationship between Ms. Herdrich and Carle Clinic and HAMP is much closer to commercial relationships where claims have been held not to be preempted. *Mackey*, 486 U.S. at 833; *Arizona State Carpenters*, 125 F.3d at 724; *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471 (4th Cir. 1996). The state claims at issue, which protect consumers against fraud and protect third party beneficiaries of contracts from bad faith and unfairness, cannot be preempted because those claims do not significantly impact any ERISA-governed relationship.^{14/}

Moreover, the state law claims at issue here involve areas of traditional state concern. Consumer protection laws -- be they common law or statutory enactments -- are areas of traditional state regulation where courts must presume that ERISA does not preempt the state's police power unless Congress has made clear its intent to do so. *Travelers*, 514 U.S. at 655; *Dillingham*, 519 U.S. at 325. Outside the ERISA context, this Court has acknowledged that state laws relating to fraudulent business dealings are an area of traditional state regulation. For example, in *Cippolone v. Liggett Group*, 505 U.S. 504, 516

^{14/} The Seventh Circuit described the Illinois Consumer Fraud Act as a "set of general business norms" and an "all-purpose truth-in-business statute." *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) (although the court found that ERISA preempted claim that deceptive information was provided, this decision was pre-*Travelers*, and there was no finding whether the HMO was an ERISA entity).

(1992), state law claims relating to fraudulent and/or misleading information from a cigarette manufacturer that were unrelated to the advertising or promotion of cigarettes were held not preempted by federal law regulating cigarette warning labels and advertisements. The state consumer protection laws that were not preempted were, generally, fraud-type claims, including claims of failure to warn, breach of express warranty, breach of the duty not to make false statements of material fact or to conceal such facts, and conspiracy to misrepresent or conceal material facts. *Id.* at 530-31.

In recent ERISA cases, courts have recognized that similar state law fraud claims are exercises of traditional state power which are not preempted. *See Woodworker's Supply, Inc. v. Principal Mutual Life Insurance Company*, 170 F.3d 985, 991 (10th Cir. 1999) (state unfair trade practices act and fraud claim not preempted because claim of fraudulent inducement against insurer was based upon its role as seller of insurance, not its role as administrator of plan); *Wilson v. Zoellner*, 114 F.3d 713 (8th Cir. 1997) (state law of negligent misrepresentation not preempted); *Morstein v. National Insurance Services, Inc.* 93 F.3d 715, 722 (11th Cir. 1996) (state law claim of fraudulent inducement to enter into ERISA plan not preempted); *Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (same).

Like the claims in *Cippolone* and other recent ERISA cases, the state laws at issue here require nonfraudulent dealing in contracts and business practices and are an exercise of the traditional state police power to prohibit fraud. Consequently, the state law claims at issue are not preempted because they are areas of traditional state regulation and Petitioners are not ERISA-governed entities for purposes of the state law allegations.

II. ERISA FIDUCIARIES ARE LIABLE TO THE PLAN FOR RESTITUTION OF BONUSES AND PROFITS WHICH THEY GAIN BY THEIR COMMISSION OF FIDUCIARY BREACHES.

Assuming that this Court finds that the district court had subject matter jurisdiction and that Ms. Herdrich alleged

cognizable claims under ERISA's fiduciary duty rules, then she is entitled to seek restitution or disgorgement of profits on behalf of the plan. 29 U.S.C. §§ 1109 & 1132(a)(2); *Mertens v. Hewitt Associates*, 508 U.S. 248, 256, 260, 262 (1993). Although Ms. Herdrich did not specify in her Complaint under which subsection of ERISA § 502(a) she was proceeding, a close reading of the Complaint confirms that she was proceeding under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2). The Seventh Circuit read the Complaint as such. *See Herdrich*, 154 F.3d at 380. Ms. Herdrich requested relief on behalf of the plan, and she may only obtain such under ERISA § 409, as enforced through § 502(a)(2).^{15/}

"Section 409 reflects ERISA's adoption of common law trust principles." *Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406, 1411 (9th Cir. 1988); *see generally Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1986) ("Rather than explicitly enumerating all of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility."). ERISA § 409 establishes that plan fiduciaries are personally liable to the plan to make good to the plan any losses resulting from a fiduciary breach and to restore to the plan any profits from that breach. 29 U.S.C. § 1109. This provision permits other remedies that make the plan whole or otherwise cure the breach, such as removal of a fiduciary and is consistent with ERISA's goal of protecting employee benefit plans as entities unto themselves. *Id.*; *see Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). Accordingly, under traditional trust law principles and ERISA

^{15/} If the Court reaches the issue of remedies, *amici* suggest that the Court should not go beyond remedies available under § 502(a)(2). *See, e.g., Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 139 n.5 (1985) (where this Court specifically stated what it was not deciding). The lower courts are currently grappling with a variety of remedy issues under § 502(a)(3), 29 U.S.C. § 1132(a)(3). *Compare, e.g., Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998), *cert. denied*, 120 S. Ct. 170 (1999) with *Strom v. Goldman, Sachs & Co.*, 1999 WL 639844 (No. 98-7090) (2d Cir. Aug. 24, 1999). These issues are not before the Court in this case.

§ 409, restitution and disgorgement are available as equitable remedies. *Mertens v. Hewitt Associates*, 508 U.S. at 256, 260, 262.

Under the RESTATEMENT (THIRD) OF TRUSTS, when trustees breach their duty of loyalty, beneficiaries may bring suit to recover any profits made by the trustees through the breach of their duties to the trust. RESTATEMENT (THIRD) OF TRUSTS, § 205(a)(1990). This is similar to interpretations of the duty of loyalty under ERISA. *See Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406, 1411 (9th Cir. 1988), *quoting Leigh v. Engle*, 727 F.2d 113, 122 (7th Cir. 1984); *Donovan v. Bierwith*, 680 F.2d 263, 271 (2d Cir. 1982); *Eaves v. Penn*, 587 F.2d 453, 457 (10th Cir. 1978). The fundamental reason for such a rule is to act as a deterrent against fiduciaries engaging in disloyal conduct by denying them the profits of their breach. G. T. Bogert, TRUSTS, *Creation of Constructive Trusts* § 87 (6th ed. 1987) (where the fiduciary has violated the duty of undivided loyalty a constructive trust may be imposed; this applies to prevent any unjust enrichment of the trustee as a result of any breach of trust) (emphasis added).

Moreover, the RESTATEMENT (FIRST) OF RESTITUTION recognizes the special relationship which fiduciaries have with their beneficiaries. "A fiduciary who has acquired a benefit by a breach of his duty as fiduciary is under a duty of restitution to the beneficiary." RESTATEMENT (FIRST) OF RESTITUTION at § 138(1) (1936). As in the instant case, "[w]here a fiduciary in violation of his duty to the beneficiary receives or retains a bonus or commission or other profit, he holds what he receives upon a constructive trust for the beneficiary." *Id.* at § 197; *accord*, § 160, cmt. c. Significantly, this rule is applicable even if the profit received by the fiduciary is not at the expense of the beneficiary. Relief is not based on the harm done to the beneficiary, "but [instead] rests upon a broad principle of preventing a conflict of opposing interest in the minds of fiduciaries, whose duty it is to act solely for the benefit of their beneficiaries." RESTATEMENT (FIRST) OF RESTITUTION § 197 cmt. a (1936). *Accord*, G. T. Bogert, TRUSTS, *Creation of Constructive Trusts* § 86 (6th ed. 1987). It makes no difference whether the bonus was given to the fiduciaries to induce them

to violate their fiduciary duties or whether the bonus was received in good faith, as long as it was received for an act done by them in connection with the performance of their duties as a fiduciary. RESTATEMENT (FIRST) OF RESTITUTION § 197, cmt. a (1936).

Consistent with traditional principles of trust law and restitution as a form of equitable relief, courts have ordered disgorgement of profits obtained through a fiduciary breach to be paid to the plan as equitable relief. *Waller v. Blue Cross of California*, 32 F.3d 1337 (9th Cir. 1994); *Amalgamated Clothing*, 861 F.2d at 1411. In this case, Ms. Herdrich has requested disgorgement to the plan of the bonuses which the fiduciaries received due to their breaches. Her prayer for relief meets the definition of restitution, is equitable relief within the meaning of ERISA § 409, and should be granted.

CONCLUSION

For the foregoing reasons, AARP, National Senior Citizens Law Center and National Employment Lawyers Association urge the Court to hold that the district court lacked subject matter jurisdiction over Ms. Herdrich's state law claims because the claims could not be brought under ERISA's civil enforcement provisions, removal was improper, and the state law claims at issue should be remanded to state court. Should the Court find that the district court had subject matter jurisdiction and Ms. Herdrich has alleged cognizable claims under ERISA, then the Court should hold that ERISA fiduciaries are liable for restitution to the State Farm ERISA plan of bonuses and profits which they gained by commission of fiduciary breaches.

Respectfully submitted,

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